DOCUMENT RESUME

ED 342 147	EC 300 906

AUTHOR	Nelson, C. Michael; Pearson, Cheryll A.
TITLE	Integrating Services for Children and Youth with Emotional and Behavioral Disorders. Current Issues in Special Education No. 1.
INSTITUTION	Council for Exceptional Children, Reston, Va.; ERIC Clearinghouse on Handicapped and Gifted Children, Reston, VA. ERIC/OSEP Special Project.
SPONS AGENCY	Special Education Programs (ED/OSERS), Washington, DC.
REPORT NO	ISBN-0-86586-218-4
PUB DATE	91
CONTRACT	RI88062007
NOTE	213p.
AVAILABLE FROM	Council for Exceptional Children, Publication Sales, 1920 Association Dr., Reston, VA 22091 (Stock No. P364: $25.00; members, $17.50).
PUB TYPE	Guides - Non-Classroom Use (055) -- Information Analyses (070)
EDRS PRICE	MF01/PC09 Plus Postage.
DESCRIPTORS	*Agency Cooperation; *Behavior Disorders; Child Advocacy; Court Litigation; Definitions; *Delivery Systems; Demography; Demonstration Programs; Educational Planning; Elementary Secondary Education; Eligibility; *Emotional Disturbances; *Family Programs; Financial Support; Legislation; Mental Health Programs; Models; Policy Formation; *Program Development; Program Evaluation; Program Implementation
IDENTIFIERS	Alaska; California; Kentucky

ABSTRACT

This book is intended to provide an information base for policy and program planners developing collaborative interagency programs for children and youth with emotional and behavioral disorders (EBD). Its focus is on the multiagency planning and services required by such children and their families. Guidelines for program development are presented as well as program models, research data, and suggested resources. Chapter 1 presents a rationale for interagency services to EBD children and youth based on child and family demographics and the history of interagency services to this popoulation. In chapter 2 the EBD population is described in terms of their behavioral characteristics and the definitions used by various agencies and professional disciplines. Chapter 3 presents information regarding legislation, litigation, funding mechanisms, and advocacy issues affecting interagency collaboration. Chapter 4 describes the most prevalent conceptual models embraced by professionals who provide mental health and education services to EBD children and youth. Implementation strategies and issues are discussed in chapter 5, and the desired outcome and benefits of collaborative programs are highlighted in chapter 6. Chapter 7 contains descriptions of several existing models of interagency service delivery. Conclusions and recommendations are provided in chapter 8. Seven extensive appendices include: a Kentucky legislative bill; a list of 111 interagency resources; and various sample agreements, forms, annual reports, and models from Kentucky, Alaska, and California. (99 references) (DB)

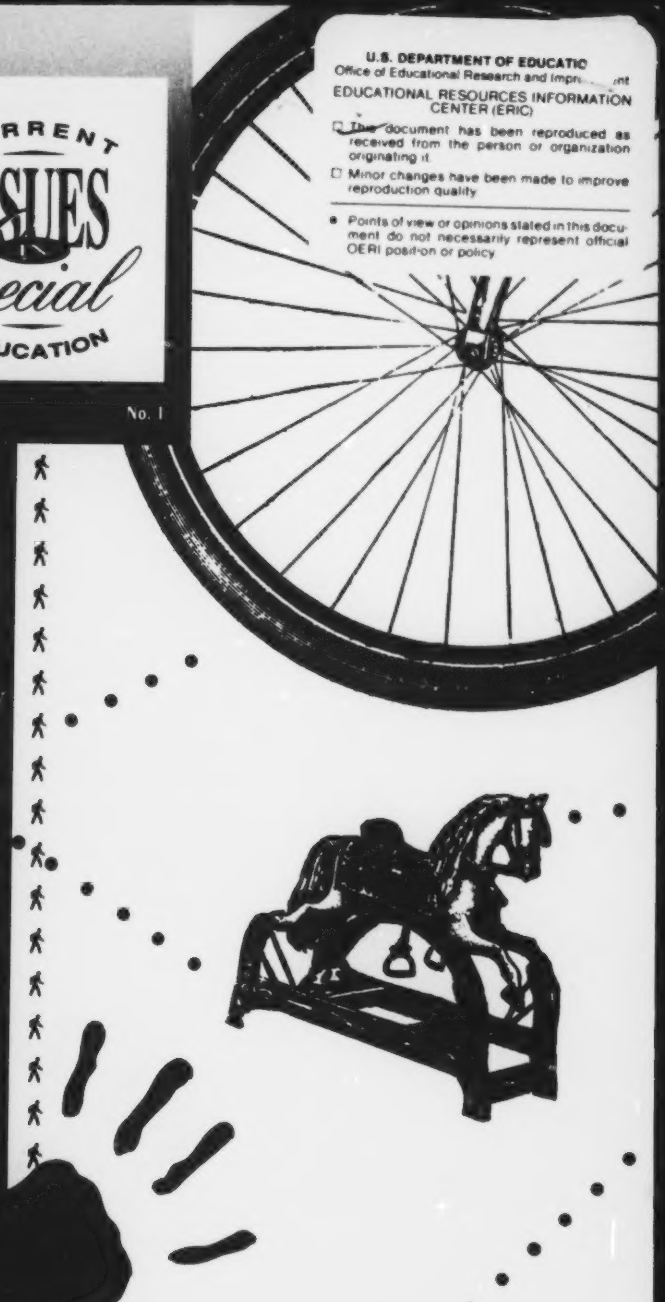
ED342147

U.S. DEPARTMENT OF EDUCATIC
Office of Educational Research and Impr[illegible]nt
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☐ ~~This~~ document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
● Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

CURRENT
ISSUES
IN
Special
EDUCATION

No. 1

Integrating Services for Children and Youth with Emotional and Behavioral Disorders



EC 300906

CEC

ERIC

BEST COPY AVAILABLE

CURRENT ISSUES IN Special EDUCATION
No. 1

Integrating Services for Children and Youth with Emotional and Behavioral Disorders

C. Michael Nelson

Cheryll A. Pearson

Published by The Council for Exceptional Children

A Product of the ERIC Clearinghouse on Handicapped and Gifted Children

Library of Congress Catalog Card Number 91-76774

ISBN 0-86586-218-4

A product of the ERIC/OSEP Special Project, the ERIC Clearinghouse on Handicapped and Gifted Children

Published in 1991 by The Council for Exceptional Children, 1920 Association Drive, Reston, Virginia 22091-1589
Stock No. P364

This publication was prepared with funding from the U.S. Department of Education, Office of Special Education Programs, contract no. RI88062007. Contractors undertaking such projects under government sponsorship are encouraged to express freely their judgment in professional and technical matters. Prior to publication the manuscript was submitted for critical review and determination of professional competence. This publication has met such standards. Points of view, however, do not necessarily represent the official view or opinions of either The Council for Exceptional Children or the Department of Education.

Printed in the United States of America
10 9 8 7 6 5 4 3 2 1

Contents

Foreword v
Acknowledgments xi
About the Authors xiii
Chapter 1 A Rationale for Interagency Services 1
  Historical Background 1
  The Needs of EBD Children and Their Families 5
Chapter 2 Characteristics and Agency Definitions 9
  Characteristics of EBD Children and Youth 9
  Definitions of the Population 11
Chapter 3 Legislation, Litigation, Advocacy, and Funding Mechanisms 17
  Federal and State Legislation 17
  Response to Litigation 21
  The National Special Education and Mental Health Coalition 22
  Grant Programs and Funding Mechanisms 23
  Funding Base for Kentucky IMPACT 25
Chapter 4 Professional Roles and Conceptual Models 29
  Interagency Professional Roles 29
  Conceptual Models 30
  A System of Care 33
Chapter 5 Implementation 39
  Strategies for Developing a System of Care 39
  Interagency Program Planning and Development 48
  Problems and Barriers 53
  Problem Solving 58
Chapter 6 Outcomes and Benefits 65
  Desired Outcomes 65
  Designing an Evaluation Plan 70
Chapter 7 Model Programs 73
  The Alaska Youth Initiative 73
  Bluegrass IMPACT 75
  The Ventura Model 78
Chapter 8 Conclusions and Recommendations 81
Appendix A House Bill 838, General Assembly, Commonwealth of Kentucky 87
Appendix B Interagency Resources 93
Appendix C Bluegrass IMPACT Memorandum of Agreement and Consent Form 109
Appendix D Kentucky IMPACT Case Conference Format 119
Appendix E 1991 Annual Report on the Alaska Youth Initiative 123
Appendix F Bluegrass IMPACT, Accomplishments to Date 149

Contents (Continued)

Appendix G The Ventura Model 167
References 201

Foreword

This book provides an information base for policy and program planners interested in developing collaborative interagency programs for children and youth with emotional and behavioral disorders (EBD). Its focus is on children and their families who are affected by EBD to the extent that they require multiagency planning and services to meet their needs. We present considerations in planning and developing interagency programs, as well as program models, research data, and information concerning resources. Guidelines for program development also are provided.

The book is organized into eight chapters. Chapter 1 presents a rationale for interagency services to EBD children and youth based on child and family demographics and the history of interagency services to the population. In Chapter 2 the EBD population is described in terms of their behavioral characteristics and the definitions used by various agencies and professional disciplines. Chapter 3 presents information regarding legislation, litigation, funding mechanisms, and advocacy issues affecting interagency collaboration. Chapter 4 describes the most prevalent conceptual models embraced by professionals who provide services to children and youth with EBD in the mental health and education fields. Implementation strategies and issues are presented in Chapter 5, and the desired outcomes and benefits of collaborative programs are highlighted in Chapter 6. Chapter 7 contains descriptions of several existing models of interagency service delivery. Our conclusions and recommendations are provided in Chapter 8. The appendices include a list of resources.

Interagency collaboration in providing for EBD children and their families is a new and unfamiliar activity for many professionals who are accustomed to working in the relatively isolated context of their discipline and agency. However, economic factors, recent legislation, and the realization that such collaboration must occur if the needs of this population are to be met have provided the impetus for interagency programming. Moreover, the success of a few model projects (e.g., the Ventura Model; see page 167) has demonstrated that effective interagency collaboration is possible.

Two problems exist with regard to serving the EBD population. The first is that historically, children with mental health needs have suffered from a lack of services in many schools and communities. The second is that services, where they are available, have been uncoordinated across agencies, resulting in fragmentation and duplication of services, thus costing families and taxpayers millions of dollars annually. Whether due to a lack of coordination, of funding, of public support, or to a combination of these variables with the unfortunate demographics that characterize American children and youth who are susceptible to severe mental illness, more social interventions have failed than have succeeded.

Factors responsible for these problems include confusion about who these children and youth are, how many are in need of services, whose responsibility it is to provide these services, and what treatment strategies are most appropriate and effective. Mental health and social service agencies tend to target children and youth who are defined as seriously emotionally disturbed (SED) and therefore who are at risk for restrictive, out-of-community placements, such as psychiatric hospitalization. On the other hand, schools identify pupils as EBD in terms of their need for special education services. Interagency programs have targeted children and youth who are at extreme risk for psychiatric hospitalization. However, we feel the needs of these individuals are best met in the context of a network of community resources for children and their families that address the full continuum of emotional and behavioral disorders.

Because of the federal mandate to provide special education and related services to EBD pupils, more data is available regarding the prevalence of such children in school as well as the public education programs available for them than for those who need or receive mental health services in their communities. However, it is widely recognized that school-age children with EBD are among the most underidentified and underserved of all students with disabilities. Even compared with federal prevalence estimates that have been reduced over the years from 2% to 1.2% of the school population (Kauffman, 1989), less than 1% of school children currently are identified and served under the EBD category or its equivalent (Nelson, Rutherford, Center, & Walker, 1991). Of all children placed in special education programs, only 9% are identified as EBD, according to the U. S. Department of Education (1990).

The actual prevalence of EBD among children and youth is difficult to determine because agreement regarding definition is lacking, the measurement of socioemotional disturbances is difficult, and the cost and practical obstacles involved in conducting epidemiological research concerning children's mental health are great (Stroul & Friedman, 1986). Estimates of the prevalence of emotional and behavioral problems in school age populations range from 3 to nearly 12%, depending upon the criteria used. Authorities consider 3 to 6% as a realistic estimate of the prevalence of school children who need special education and related services due to their emotional and behavioral disorders (Institute of Medicine, 1989). Using a criterion of "clinical maladjustment," Gould, Wunsch-Hitzig, and Dohrenwend (1981) reviewed epidemiological studies and estimated that the prevalence among children was 11.8%.

Children identified as SED by the mental health system experience major deficits in the areas of self-care, interpersonal relationships, family life, self-direction, and education occasioned by their long-standing emotional disorders. Knitzer (1982) estimated that the prevalence of children with SED is 5%, or 3 million children in the United States. This figure includes only those youngsters who exhibit severe and persistent problems, whereas the 11.8% estimate includes all children with all degrees of emotional disturbances (Stroul & Friedman, 1986). The population of children and youth identified as SED by the mental health system overlaps considerably with pupils labeled SED[1] by the schools for educational purposes. We will use the term EBD to refer to the total population of children and youth affected by emotional and behavioral problems across the full continuum of severity. To be consistent with prevailing practices, when discussing children specifically targeted for mental health services because of their serious and chronic emotional problems, we will use the designation SED. (See Chapter 2 for a discussion of population definition and characteristics.)

Many factors have contributed to the underidentification of EBD children and the failure to serve them in schools and communities. Confusion about responsibility for related services and different definitions of EBD among states as well as different interpretations of state definitions by individual school districts have contributed to a wide variation in the number of EBD students identified and served among states and school districts. In addition, the high costs of providing services needed by some of these pupils (e.g., residential treatment), the particular stigma associated with presumed mental illness, and the protection afforded identified students from suspension and expulsion by schools have contributed to the reluctance of schools to identify and serve EBD pupils (Nelson et al., 1991; Friedman, 1985; Yell, 1989).

Schools are extremely hard pressed to provide services that meet the multiple and diverse needs of students with EBD. Possibly more than for any other special education category, related services for this population are in short supply. Developmental and medical services for pupils with mental retardation and related physical disabilities are guaranteed through federal legislation, but mental health funding at both federal and state levels has been perennially lacking, especially for children's services.

---

[1] The label seriously emotionally disturbed (SED) was adopted in the Public Law 94–142 definition of this population. Individual states may use an alternate label, as long as the label and accompanying definition identify a similar population of students. At this writing, 14 states use the SED label, the remainder having chosen an alternate designation (e.g., emotionally handicapped, behaviorally disordered). (D. Roe, personal communication, May, 1991.)

In part, the failure to provide adequate financial support is due to the lack of advocacy on behalf of troubled children and youth by state and national groups, as well as by parents (Knitzer, 1989). Moreover, much of the available funding has provided for psychiatric hospitalization rather than for outpatient or preventive services (Institute of Medicine, 1989). Collaboration among schools and other agencies to serve EBD children and youth are less comprehensive and less well developed than in the field of developmental or related disabilities (Knitzer, 1982; Knitzer, Steinberg, & Fleisch, 1990; Peacock Hill Working Group, 1991).

In communities as well as in schools, appropriate services for children and youth with EBD are lacking. More than 20 years ago, the Joint Commission on the Mental Health of Children (1969) observed that millions of children were not receiving needed mental health services. The President's Commission on Mental Health (1978) echoed the Joint Commission's conclusion, finding that few communities provided the volume or continuum of programs necessary to meet children's mental health needs. More recently, Knitzer (1982) reported that two-thirds of all SED children do not receive the services they need. Due to the lack of community-based programs and services, many others receive inappropriate and often unnecessarily restrictive care, often in state mental hospitals (Stroul & Friedman, 1986). The isolation and fragmentation of service agencies also works against the implementation of appropriate programs for students with EBD (Friedman, Duchnowski, & Henderson, 1989). Many students that schools identify as EBD have problems outside the educational system that bring them into contact with mental health, juvenile justice, and other community agencies. The multiplicity of these students' problems and the number of agencies involved with them demand active collaboration of social agencies to mount necessary comprehensive interventions. Unfortunately, few models for this type of collaboration exist, and, in many cases, laws and policies actually deter, if not prohibit, their implementation (Peacock Hill Working Group, 1991).

The consequences of the lack of appropriate services for EBD children and youth are grim. In school, these pupils are significantly more likely than youth with learning disabilities to receive failing grades (Wagner & Shaver, 1989). Over 40% of EBD students 14 years of age and older drop out of school, as opposed to only 35% who graduate with a diploma or certificate (U. S. Department of Education, 1990). In the first 6 years of the 1980s, the psychiatric hospitalization of children increased more than 400%; over 50,000 children were served in psychiatric hospitals in 1986 (Weithorn, 1988). Wagner (1989) found that nearly 50% of students who had been identified as EBD were arrested within 2 years of leaving school. The failure to identify and provide early intervention services to EBD children and their families, and to develop a full continuum of care between the extremes of outpatient treatment and psychiatric hospitalization has resulted in a staggering loss of human potential. Moreover, it has cost taxpayers millions of dollars in terms of long-term institutional care for adults whose problems were not recognized or adequately treated when they were children.

Acknowledgments

The authors are indebted to numerous persons who provided information and inspiration for this book. We wish to express our particular gratitude to the following colleagues who invested significant amounts of time and energy in thoughtful reviews and helpful suggestions for the manuscript: Kerby Neill, Ph D, Director of the Graham B. Dimmick Child Guidance Service, Lexington, Kentucky; Eugene Edgar, Ph D, Professor of Special Education, University of Washington; Steven R. Forness, Ed D, Professor and Inpatient School Principal, UCLA Neuropsychiatric Hospital; and Peter Leone, Ph D, Associate Professor of Special Education, University of Maryland. We also are grateful to Kathleen McLane, Associate Director of the ERIC Clearinghouse on Handicapped and Gifted Children, The Council for Exceptional Children, for her guidance and patience.

About the Authors

C. Michael Nelson began his special education career as a teacher of adolescents with learning and behavior disorders. After earning a master's degree in school psychology, he worked as a child psychologist at the University of Kansas Medical Center, while simultaneously pursuing a doctorate in special education with an emphasis on behavior disorders. He received his EdD from the University of Kansas in 1969 and took a position with the Department of Special Education at the University of Kentucky, where he currently is a full professor and coordinates the Leadership Training Program. Dr. Nelson has authored or edited eight books, and has written numerous textbook chapters and articles in refereed journals. With Robert Rutherford and Bruce Wolford, he co-authored the Correctional/Special Education Training Project and served as coordinator of inservice curriculum development on that federally funded grant project. He has prepared teachers of children and youth with behavior disorders at the pre- and inservice levels and has served as principal investigator on a number of personnel preparation grants. He is a past president of the Council for Children with Behavioral Disorders. Currently, he is involved in developing systematic procedures for the assessment, identification, and delivery of services to pupils with emotional and behavioral disorders in Kentucky, as well as establishing interagency services on behalf of these children and their families. He is vice-chairman of the Regional Policy Council for Bluegrass IMPACT.

Cheryll A. Pearson began her career as a special education teacher on a Navaho Indian reservation in northeastern Arizona. She entered graduate school at Arizona State University, completing her master of science degree in school psychology. Upon moving to Kentucky she completed her graduate education, obtaining her PhD in school psychology at the University of Kentucky. Dr. Pearson has been employed as a school psychologist for the Scott County Public Schools for the past 4 years, and has been actively involved in providing services for children with emotional or behavioral problems, including children served by Bluegrass IMPACT. She has authored or co-authored several chapters and research articles on intervention acceptability, assessment issues, cultural differences, and delinquency. Recently, Dr. Pearson received an award for accomplishment in research from the Kentucky Association for Psychology in the Schools.

1. A Rationale for Interagency Services

Historical Background

As previously mentioned, children and youth with EBD often require multiple services that involve several agencies, including education, mental health, child welfare, juvenile justice, and health. The Joint Commission on the Mental Health of Children (1969) and the President's Commission on Mental Health (1978) recommended that an integrated network of services be developed in communities to meet the needs of children and youth with SED. In its 1986 Annual Report to Congress, the U. S. Department of Education noted that this student population presents an extremely complex array of human service needs. These needs often go beyond special education and may include counseling, therapy, and residential treatment. Unless services are coordinated across agencies and among professionals, the effectiveness of each component is jeopardized. This report further described the improvement of services to this population as a complex service delivery challenge because of the variety of services required and the large number of agencies and providers involved.

Despite widespread recognition of these needs, the results of contemporary efforts to establish comprehensive community-based services for both children and adults with EBD have been disappointing. The Community Mental Health Centers (CMHC) Act of 1963 allotted federal funds for the construction of comprehensive community mental health centers. Subsequent legislation, enacted in 1965, expanded federal support to cover CMHC operations. However, as Senator Edward Kennedy (1990, p. 1238) observes, "despite 25 years of federal policy efforts, community-based treatment opportunities for the seriously mentally ill are still largely inadequate." According to Kennedy (1990), the last 4 decades have been a time of both hope and disappointment for the mentally ill and their families. Beginning in the 1950s, new developments, including the introduction of psychotrophic drugs, therapeutic treatment communities, and the observation that long-term institutionalization creates additional behavioral problems, brought widespread consensus that confinement of the mentally ill should be replaced by a system of community care. As President John F. Kennedy stated in his 1963 State of the Union message, "The abandonment of the mentally ill to the grim mercy of custodial institutions too often inflicts on them a needless cruelty which this nation should not endure" (cited in Kennedy, 1990, p.1238). However, despite the 1963 law and its 1965 amendments, and a proliferation of CMHCs, the removal of patients from mental hospitals was not matched by the growth of the community-based system of care that President Kennedy envisioned. Instead, the deinstitutionalized mentally ill often faced a future of isolation, abandonment, and despair (Kennedy, 1990).

As Behar (1990) points out, major changes in public policy toward deinstitutionalization of children and youth have had less than desired effects. For example, the Juvenile Justice and Delinquency Prevention Act of 1974 provided for the deinstitutionalization of status offenders, setting an expectation for a concomitant increase in community-based services. However, many of these children subsequently were diverted into the mental health system, where they were placed in psychiatric hospitals. Public Law 96–272, which was designed to strengthen families so that children could remain in their homes, resulted in a substantial shift of children from the foster care and child welfare system into the mental health system, again with no increase in community-based mental health services (Behar, 1990).

Pallak (1990) observes that public policy regarding the mentally ill has been hampered by a combination of negative attitudes and events since the passage of Public Law 88–164, which provided federal support for the preparation of school personnel to work with EBD children. Many citizens still believe the stereotype of the mentally ill as either criminally insane or with intractable, unmanageable, and unpredictable diseases. The public tends to link mental illness with violence and to believe that mentally ill persons should be incarcerated for the protection of society. Meanwhile, most of the mental health disciplines have concluded that long-term institutionalization is part of the problem rather than the solution, and that mental health services can best be delivered in community-based programs (Chamberlin & Rogers, 1990). Mental health services have been shaped dramatically by developments in the private health service and insurance sectors, and public programs such as Medicaid sharply limit the availability of even minimal services for the mentally ill (Pallak, 1990). Pallak asserts that serious and chronic disorders will almost certainly never be covered by private insurance companies.

Public attitudes, policies, and programs for the mentally ill provide a context for analyzing and understanding the plight of children and youth with EBD. In her classic study of children with needs for mental health services in this country, Knitzer (1982) concludes that these children are unclaimed by the public agencies responsible for serving them. Knitzer (1984) also identified the extreme fragmentation of services and the consistent failures of connections between agencies as critical weaknesses in the child mental health system. Numerous studies (e.g., Knitzer, 1982), reports (e.g., U. S. Department of Education, 1986), and commissions (e.g., Joint Commission on the Mental Health of Children, 1969) have identified a chronic pattern of problems associated with the system's response to the increasing needs of EBD children and youth:

- The failure to address the joint needs of children and their families
- State policies and practices that hinder the coordination of care among the mental health, education, juvenile justice, and child welfare systems
- Limitations imposed by the local policies and practices of agencies serving children and families; and
- Fiscal incentives that promote the most restrictive care.

In testimony before the Subcommittee on the Handicapped of the Committee on Labor and Human Resources of the United States Senate, Forness (1989) indicates that most communities lack a range of appropriate community-based service options for children with EBD. Children are not always served in the setting that best meets their needs. There is an over-reliance on residential care and a lack of day treatment services that would enable a child to remain in his or her community. Behar (1990) summarizes research demonstrating that 40 to 50% of children placed in psychiatric hospitals are being placed unnecessarily. Furthermore, the lack of family support and other "midrange services" (Behar, 1990)—especially in the areas of family counseling and therapy, day and respite care, and structured after school programs and recreation—means that families often are not able to keep their child at home, resulting in placements that may be more restrictive than necessary. Indeed, recent experience has confirmed that intensive community-based services provided to the child and family can minimize the need for residential treatment or hospitalization and that these restrictive treatment settings are both overused and more expensive than services provided in communities (Behar, 1985, 1990; Friedman & Street, 1985; Knitzer, 1982; Stroul & Friedman, 1986; Weithorn, 1988).

The reasons why a comprehensive system of coordinated interagency services for EBD children and their families has not developed in this country are apparent, but the causes are far more difficult to rectify. Obstacles and barriers exist at the levels of federal and state legislation and policy, professional disciplines, and individual service agencies. At the federal level, the absence of a law mandating free and appropriate mental health services to children and families, analogous to the law requiring schools to assume responsibility for the education of students with disabilities, is a major barrier (Forness, 1989). Public Law 99–660, the Comprehensive Mental Health Service Act of 1986, mandates that states plan and implement a comprehensive system of community-based care for the seriously mentally ill. It authorizes federal grants to assist in the planning effort and requires that federal technical assistance be provided to states requesting it (Kennedy, 1990).

However, other federal policies mitigate against effective state planning. For example, Medicaid rules and regulations have not been adapted to the needs of the seriously mentally ill. The enactment of the Reagan administration's Alcohol, Drug Abuse, and Mental Health Block Grant in 1987, and the repeal of the Mental Health Systems Act seemed to signify abdication of federal responsibility for this population (Kennedy, 1990). Policies, as well as fiscal and other incentives necessary to encourage coordination among state agencies, are lacking in many states. Mental health, social services, education, juvenile justice, recreation, and vocational rehabilitation service systems are involved with EBD children and youth, but in most states there is no clear delineation of the roles and responsibilities of these different agencies, and differences exist in their interpretations and compliance with federal or state policies (Forness, 1989).

Another set of obstacles exist in the bureaucratic traditions separating services for adults and for children. Public Law 99–660 mandated state plans for mentally ill individuals, but contained no specific requirement regarding such services to children. Although the elements necessary for providing services to adults with mental illness are fairly well understood, designing services for children presents a greater challenge. Demonstration projects under the Community Support Program for adults have been functioning for a decade, but projects sponsored under the analogous Child and Adolescent Service System Program (CASSP) have a much shorter history. Also, funding the required case management for CASSP projects appears to be a problem for certain states (Kennedy, 1990).

The structure of service agencies also works against the implementation of appropriate community-based services for children and youth with EBD. Forness (1989) cites several structural obstacles, including: (a) differences in definitions of target populations among agencies; (b) differences in eligibility requirements and criteria; and (c) the need for confidentiality, which prevents the sharing of information and referrals between agencies. In addition, competition for clients and funding, as well as agency turf issues interfere with collaboration. Studies (Knitzer, 1982; Friedman & Street, 1985; Stroul & Friedman, 1986) report little effective coordination or collaboration in the planning, administration, financing, or delivery of services among major child service agencies. This lack of coordination leads to a fragmented service delivery system with gaps in services and inadequate case management. Different agency policies and mandates impose inconsistent definitions, eligibility requirements, funding mechanisms, and treatment modalities. These problems are compounded by narrow definitions of the roles of various mental health disciplines, which further impede the integration of service capabilities (Forness, 1989).

The Needs of EBD Children and Their Families

Widespread professional agreement that many children and youth with EBD, as well as their families, require multiple services that involve several agencies and disciplines has been documented previously. Demographic studies of children and families having mental health needs provides further dramatic justification for coordinated interagency services. The 1988 National Health Interview Survey of Child Health (Freiberg, 1991) reported that one in five American children has had a developmental, learning, or emotional problem. Such problems are twice as likely in children from disrupted families as in children from intact, two-parent families. In this survey of 17,000 youngsters, the frequency of emotional or behavioral problems was 36% greater among males than females. Learning disabilities and emotional problems were somewhat more common among children from low income and less well-educated families. Children from single-parent families and families with step-parents were two to three times more likely to have had emotional problems than those living with both biological parents. The prevalence of learning disabilities among children in homes without two natural parents also was higher, but less striking, while developmental delays varied little by family type. Freiberg (1991, p. 36) observes that "the alarmingly high prevalence of emotional . . . problems among today's children and the observed relationship between family disruption and youthful problem behavior reinforce public concerns about the increasing number of U.S. children who are being raised in something other than harmonious two parent families." Elsewhere (Nelson & Pearson, in press) we have summarized research showing that children and youth who are identified as delinquent have family demographics very similar to EBD children and adolescents.

In the authors' home state of Kentucky, legislation mandating interagency services for SED children and their families recently has been passed. The implementation of these services includes a statewide plan for evaluating services to these children and families, which includes the collection of data regarding demographic variables and the services received by clients. Data presently are available on 408 clients, ranging in age from birth through age 20. Demographic and risk factor data are reported in Table 1-1. These data clearly indicate that disruptive factors characterize many families of these children and youth, including poverty, divorce, and a history of mental illness, violence, and chemical dependence in the family. Many of these clients have had previous psychiatric hospitalization, have been physically and/or sexually abused, are discipline problems in school (including truancy), and achieve below

TABLE 1-1

Kentucky IMPACT Preliminary Demographic and Risk Factor Data (*n*=408)

Percent of Sample	
	Family/Setting Risk Factors
52.4%	Family income below poverty level
52.4%	Divorce between natural parents
30.0%	Three or more siblings
11.5%	Adopted
16.3%	Parent psychiatric hospitalization
18.7%	Parent convicted of felony (current or previous)
14.2%	Siblings institutionalized (current or previous)
17.2%	Siblings in foster care
37.8%	History of family mental illness
58.1%	History of family violence
48.1%	History of family chemical dependence
11.2%	Family unavailable for aftercare
40.3%	Negative peer influence
	Child Risk Factors
59.6%	Previous psychiatric hospitalization
40.3%	Physically abused (reported)
36.3%	Sexually abused (reported)
15.7%	Chronic runaway (greater than 3 prior attempts)
20.6%	Suicide attempt(s)
29.0%	Chronic school truancy
69.6%	Below grade-level school achievement
8.7%	Drug/alcohol dependency
36.3%	Frequent suspension/expulsion
18.1%	Other handicapping conditions (e.g., physical, sensory)
	Child Dangerousness
4.8%	Sexually abusive (adjudicated)
1.8%	Previous felony conviction
65.1%	Dangerous to others (history of aggression/violence)
41.8%	Dangerous to self (self-injurious)
20.6%	Fire-setting

Source: Adapted from the preliminary report of the Kentucky IMPACT Evaluation Team, Robert Illback, July 26, 1991. Reprinted by permission.

grade level academically. In addition, the majority have a history of aggression or violence toward others, and nearly as many are self-injurious. In an earlier sample of 143 clients, 74% were receiving services from the Department of Social Services, 81% were clients of community mental health centers, 67% were in special education, and 28% received services from the juvenile court system (Illback, 1991).

Such data provide convincing evidence that SED children and their families both need and use the services of multiple professions and agencies. But do they also suggest that these services should be community-based, rather than provided in institutional settings? The enormous cost of psychiatric hospitalization, incarceration in juvenile correctional programs, or long-term residential treatment programs (Behar, 1990; Jacobs, 1990) is ample justification for seeking treatment in less restrictive settings. The costs of residential treatment typically range from $30,000 to $50,000 per child per year, extending to as much as $90,000 per year for out-of-state care (Jacobs, 1990). During 1989, 500 psychiatric hospital beds were used by SED children in Kentucky, at a cost to taxpayers of 36 million dollars, or $72,000 per bed (Kentucky Cabinet for Human Resources, 1990). The average annual cost of incarcerating juveniles in this country was calculated at $29,600 per juvenile in 1989, with a range of $17,600 to over $78,800 (Allen-Hagen, 1991). Added to the costs of long-term institutionalization is the loss of tax revenue from children who fail to become self-sufficient contributors to society.

The historical policy of removing children from dysfunctional families has been replaced by a national policy of family preservation, established by Public Law 96–272, the Adoption Assistance and Child Welfare Act of 1980. This policy is supported by research demonstrating that attempts to treat children in artificial settings have been less effective than treatment designed to support the child's natural family (Allen, Golubock, & Olson, 1983).

Thus, community-based intervention for EBD children and youth is supported by a variety of factors. Johnson (1989) summarized these as follows:

- Pressures from clients, parents, and advocates
- Economic pressures
- Federal initiatives
- The need to reduce or eliminate duplication of services
- Continuing development of new and improved treatment strategies
- The need for additional comprehensive services or redistribution of existing services
- Inter/intraprofessional pressures based on the need for continuing education
- Fragmented service delivery systems
- Overlap in service definitions
- Multiple funding bases
- Multiple planning bodies
- Varying models for service delivery

In addition, achieving greater accessibility to services by clients is a powerful incentive for establishing community-based programs. Interagency planners should conduct assessments of their states and the communities to be affected by proposed interagency projects in order to identify the specific problems that should be addressed. Specific guidelines are provided in Chapter 5.

2. Characteristics and Agency Definitions

We have previously alluded to the wide range of behavioral characteristics displayed by children and youth with EBD, as well as to the considerable variability among prevalence estimates and the differences among agencies in terms of how they are defined. Both the subjectivity and ambiguity of identifying this population have contributed to disagreements about who these children are, how many need services, and what kinds of services they require (Kauffman, 1989). Here we discuss the characteristics of children identified as EBD and present definitions from several disciplinary perspectives. Population characteristics and definition exert a major influence on the eligibility requirements imposed by different agencies for their services. Thus, knowledge of the characteristics of the EBD population, as well as of definitions and classification schemes used by various disciplines, will help interagency planners achieve consensus about who they will target for services.

Characteristics of EBD Children and Youth

Recent federal and state legislation has provided strong encouragement for schools to establish preschool programs for children in the 3- to 5-year-old age group. Public Law 99–457 targeted the extension of early school-based intervention for children with disabilities from birth to 2 years of age by 1991, although states have been allowed to extend this implementation date. Furthermore, school provides a common and important social environment for all children in our society. For these reasons, it is useful to describe the behavioral characteristics of EBD children and youth in terms of their adjustments to the school's academic and social expectations.

Professionals generally concur that children's emotional and behavioral disorders may be described as acting out (externalizing) or social withdrawal (internalizing) (Quay, 1986; Walker & Fabre, 1987). Furthermore, as Walker and Bullis (1991) have observed, school children must make two primary adjustments in school. One involves adjusting to the behavioral expectations and demands of the teacher in the classroom, and includes obedience to classroom rules, attending to task, completing assigned work, and exhibiting other skills valued by teachers. These behaviors have been termed "school survival skills" and appear consis-

TABLE 2-1
Interrelationships of Bipolar Behavior Patterns and School Adjustment Types

Patterns	**Behavior**	
	Externalizing	*Internalizing*
Teacher-Related	• Acting out, noncompliant behavior • Teacher defiance • Behavioral excesses • Low achievement • Disruption of classroom ecology • High probability of referral • Resistant to social influence tactics	• High levels of appropriate classroom behavior • Nonassertive behavior patterns • Problems with self • Performance deficits • Low achievement • Low probability of referral
Types of Adjustment		
Peer-Related	• Variable peer status some acceptance some rejection • Failure to use social skills that support positive peer interactions • High levels of social engagement • High levels of negative/aggressive social behavior	• Neglected or rejected peer status • Low levels of participation in peer controlled activities • Social isolation and withdrawal • Low levels of negative social behavior

Source: From "Behavior disorders in the social context of regular class integration: A conceptual dilemma" by H. M. Walker and M. Bullis (1991), in J. W. Lloyd, N. N. Singh, & A. C. Repp (Eds.), *The Regular Education Initiative: Alternative Perspectives on Concepts, Issues, and Models*, (p. 82), Sycamore, IL: Sycamore Press. Reprinted by permission.

tently in studies of teacher behavioral standards and expectations (Cobb, 1972; Kerr & Zigmond, 1984; Kerr, Zigmond, Schaeffer, & Brown, 1986; McConnell et al., 1984; Walker & Rankin, 1983). Children also must adjust to the expectations and behaviors of peers in settings where social interactions occur (e.g., free play settings). Here, children must learn appropriate play behaviors and develop friendship patterns (Walker & Bullis, 1991).

Walker and his colleagues have studied the behavior patterns of pupils with externalizing and internalizing behavior patterns in terms of their adjustments to teacher expectations and the demands of peer socialization. These characteristics are presented in Table 2-1. As this table reveals, externalizing children exhibit high levels of behaviors that conflict with teacher's expectations and standards. On the other hand, their peer-related adjustment is characterized by much greater variability in social status and behavior. For example, the peer sociometric status of these pupils is likely to be quite variable, and they tend to display high levels of social engagement, but much of this behavior is in the form of negative or aggressive interactions such as fighting, teasing, etc. On the other hand, internalizing children tend to display few behaviors that place them in conflict with their teachers but they have consistently low levels of social status or interactions with peers. The absence of "high visibility" problems in adjusting to teacher standards and expectations seems to account for the disproportionate identification of acting-out children as EBD in school (Kerr & Nelson, 1989). Another factor is the difficulty of identifying subcategories, such as anxious-withdrawn, social isolation, and lack of social competence, that fall under internalizing disorders (Kauffman, 1989).

In family and community settings, children exhibiting externalizing behavior disorders also are more likely to be in conflict with adults and other children. For example, Patterson, Reid, Jones, & Conger (1975) found that aggressive children displayed significantly higher rates of 14 noxious behaviors at home compared with nonaggressive peers. These behaviors include disapproval, negativism, noncompliance, teasing, yelling, negative physical activity, destruction of property, crying, whining, humiliating others, high rates of motor activity, issuing coercive statements, requesting assistance with tasks they could accomplish independently, and ignoring. Referrals for community services of youngsters exhibiting these behavior patterns is higher than referrals of withdrawn children (Walker & Fabre, 1987). In addition, children with acting-out patterns of social deviance are more likely to exhibit law-violating behaviors that lead to their identification as socially maladjusted or delinquent and their diversion to the juvenile justice system. Youths with chronic patterns of antisocial and delinquent behavior are less likely to remain in community settings (Nelson & Pearson, in press).

Definitions of the Population

Knowledge of the characteristics of children and youth with EBD is useful for identifying individuals who *may* be eligible for services. However, for services to be delivered, individuals must first meet the criteria for identification as clients of the agency whose services are being requested. In order to do this, their behavioral traits or characteristics must fit the definition(s) of the population(s) served by that agency. Agency definitions of EBD children generally fall under one of two categories: those used by the educational system and those used by community human service providers. Educational definitions differ from state to state, but are based on the definition of SED in the rules and regulations of the Education of the Handicapped Act of 1975 (Public Law 94–142).

"Seriously emotionally disturbed" is defined as follows:

(i) The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance:
  (A) An inability to learn which cannot be explained by intellectual, sensory, or health factors;
  (B) An inability to build or maintain satisfactory interpersonal relationships with peers or teachers;
  (C) Inappropriate types of behavior or feelings under normal circumstances;
  (D) A general, pervasive mood of unhappiness or depression; or
  (E) A tendency to develop physical symptoms or fears associated with personal or school problems.
(ii) The term includes children who are schizophrenic or autistic[2]. The term does not include children who are socially maladjusted, unless it is determined that they are seriously emotionally disturbed. (45 C.F.R. 121a.5[b] [8] [1978]).

Widespread professional criticism has been voiced regarding this definition, primarily on the grounds of its ambiguity and its failure to discriminate effectively between students with disabilities and their nondisabled peers (Kauffman, 1989; Executive Committee of the Council for Children with Behavioral Disorders, 1987). As previously discussed, the appropriateness of the clause excluding socially maladjusted children has been questioned (Council for Children with Behavioral Disorders, 1990; Nelson et al., 1991). And, as we mentioned before, states are free to adopt their own definitions (and label) for this population as long as an equivalent group of pupils to those described in the federal definition is identified. However, so much variation exists among state definitions and local identification procedures that whether students are identified as EBD for special education services to some extent depends upon where they live (Executive Committee of the Council for Children with Behavioral Disorders, 1987).

Concerns about the suitability of this definition have led to political support for an alternate label and definition. The definition presented in Table 2-2 was passed by the Delegate Assembly of the Council for

---

[2] The National Society for Autistic Citizens successfully lobbied to have autism removed from the federal definition of SED. Until recently, it was included as a condition in the Other Health Impaired category. Public Law 101–476 authorized the creation of autism as a separate category of disability.

TABLE 2-2
Proposed New U.S. Federal Definition of EBD

Emotional or Behavioral Disorder (EBD) refers to a condition in which behavioral or emotional responses of an individual in school are so different from his or her generally accepted, age-appropriate, ethnic, or cultural norms that they adversely affect educational performance in such areas as self-care, social relationships, personal adjustment, academic progress, classroom behavior, or work adjustment.

- **EBD is more than a transient, expected response to stressors in the child's or youth's environment and would persist even with individualized interventions, such as feedback to the individual, consultation with parents or families, and/or modifications of the educational environment.**
- **The eligibility decision must be based on multiple sources of data about the individual's behavioral or emotional functioning. EBD must be exhibited in at least two different settings, at least one of which is school-related.**
- **EBD can co-exist with other handicapping conditions, as defined elsewhere in this law.**
- **This category may include children or youth with schizophrenia, affective disorders, anxiety disorders, or with other sustained disturbances of conduct, attention, or adjustment.**

Exceptional Children (CEC) (1991) as proposed by the Definition Task Force of the Mental Health and Special Education Coalition and modified by the CEC Advocacy and Governmental Relations Committee. It is clear that the proposed definition focuses more on the process of identification than on the specific content of the individual's behavior. Although it includes some redundant phrasing (i.e., inclusion of schizophrenia, affective disorders, anxiety disorders, or other sustained disturbances of conduct, attention, or adjustment), these labels clearly indicate that pupils with DSM-III-R diagnoses (see below) may be eligible for special education and related services. Moreover, this definition does not contain a clause excluding socially maladjusted pupils.

Agencies providing human services, including community mental health centers, social service agencies, residential treatment centers, and psychiatric hospitals, tend to rely upon the American Psychiatric Association's *Diagnostic and Statistical Manual*, (1987) for determining client eligibility and for assigning diagnostic classifications. In these **mental health definitions**, client eligibility for services is based on assignment to a diagnostic category by a clinician. Two sets of categories may be used in assigning a diagnosis to a child or youth. The first set consists of disorders usually first evident during infancy, childhood, or adolescence, and is presented in Table 2-3. The clinician considers these categories first; if no appropriate diagnosis is found here, a diagnosis may be considered from the adult sections of DSM-III-R.

TABLE 2-3
Diagnostic Categories of DSM-III-R for Disorders Usually First Evident in Infancy, Childhood, or Adolescence

- I. DEVELOPMENTAL DISORDERS
  - A. Mental Retardation
    - 1. Mild mental retardation
    - 2. Moderate mental retardation
    - 3. Severe mental retardation
    - 4. Profound mental retardation
    - 5. Unspecified mental retardation
  - B. Pervasive Developmental Disorders
    - 1. Autistic disorder
    - 2. Pervasive developmental disorder not otherwise specified
  - C. Specific Developmental Disorders
    - 1. Academic skill disorders
      - a. Developmental arithmetic disorder
      - b. Developmental expressive writing disorder
      - c. Developmental reading disorder
    - 2. Language and speech disorders
      - a. Developmental articulation disorder
      - b. Developmental expressive language disorder
      - c. Developmental receptive language disorder
    - 3. Motor skill disorder
      - a. Developmental coordination disorder
  - D. Other Developmental Disorders
    - 1. Developmental disorder not otherwise specified
- II. DISRUPTIVE BEHAVIOR DISORDERS
  - A. Attention-Deficit Hyperactivity Disorder (ADHD)
  - B. Conduct Disorder
    - 1. Group type
    - 2. Solitary aggressive type
    - 3. Undifferentiated type
  - C. Oppositional Defiant Disorder
- III. ANXIETY DISORDERS OF CHILDHOOD OR ADOLESCENCE
  - A. Separation Anxiety Disorder
  - B. Avoidant Disorder of Childhood or Adolescence
  - C. Overanxious disorder
- IV. EATING DISORDERS
  - A. Anorexia Nervosa
  - B. Bulimia Nervosa
  - C. Pica
  - D. Rumination Disorder of Infancy
  - E. Eating Disorder Not Otherwise Specified
- V. GENDER IDENTITY DISORDERS
  - A. Gender Identity Disorder of Childhood
  - B. Transsexualism
  - C. Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type (GIDAANT)
  - D. Gender Disorders Not Otherwise Specified
- VI. TIC DISORDERS
  - A. Tourette's Disorder
  - B. Chronic Motor or Vocal Tic Disorder
  - C. Transient Tic Disorder

Continued

TABLE 2-3 (continued)
Diagnostic Categories of DSM-III-R for Disorders Usually First Evident in Infancy, Childhood, or Adolescence

- D. Tic Disorder Not Otherwise Specified

VII. ELIMINATION DISORDERS
- A. Functional Encopresis
- B. Functional Enuresis

VIII. SPEECH DISORDERS NOT CLASSIFIED ELSEWHERE
- A. Cluttering
- B. Stuttering

IX. OTHER DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE
- A. Elective Mutism
- B. Identity Disorder
- C. Reactive Attachment Disorder of Infancy or Early Childhood
- D. Stereotype/Habit Disorder
- E. Undifferentiated Attention-Deficit Disorder

Source: From *Characteristics of Behavior Disorders of Children and Youth*, 4th ed. (pp. 124–125) by J. M. Kauffman, 1989, Columbus, OH: Merrill. Copyright 1989 by Macmillan. Reprinted by permission.

Adult diagnostic categories that are most often assigned to children or youth include the following:

- Organic mental disorders
- Psychoactive substance use disorders
- Schizophrenia
- Mood disorders
- Schizophreniform disorder
- Sexual disorders
- Adjustment disorder
- Psychological factors affecting physical condition
- Personality disorders (Kauffman, 1989, p. 123).

Each specific diagnostic category in DSM-III-R includes a description of symptoms and a discussion of other diagnostic indicators. The DSM-III-R classification system has been criticized as unreliable for children's disorders (Dumont, 1987) as well as for being too specific to account for many cases (Kauffman, 1989). Although it is used to define EBD in some states for educational purposes, psychiatric classification has little relevance for behavior management or classroom instruction (Kauffman, 1989).

Given that education and mental health systems use different classification schemes to describe children being served by both systems (Quay, 1989), it is likely that agencies planning coordinated services for children and youth with EBD will face some conflict regarding definition of the population. However, if planners and policymakers approach this task with the recognition that services should be driven by client's needs, and that definitions are a means of establishing these needs, resolution should be possible. For example, Kentucky adopted a definition of children or youth with severe emotional problems for the purposes of its statewide SED delivery system (House Bill 838). This definition includes the following criteria:

- Under the age of 18, or under 22 and receiving services prior to the age of 18 that must be continued within the system of care of maximum therapeutic benefit.
- Must have substantial limitations of major life activities in at least two of the following:
  - Self-care
  - Interpersonal relationships
  - Family life
  - Self-direction
  - Education
- A primary DSM-III-R Axis I or II psychiatric diagnosis, unless the diagnosis is solely chemical dependency, mental retardation, or developmental delay.
- Severe disability for duration of 1 year or more or judged by a qualified mental health professional to be at high risk to continue for 1 year or more without intervention.
- Special service need in two or more agencies or systems at the same time, requiring multiagency coordination and treatment planning.

The definition has been worded to include the parameters for identifying SED children and youth contained in the federal CASSP initiative (Stroul & Friedman, 1986). Although this definition reflects a predominantly mental health perspective, the educational system retains its own definition of EBD for special education and related services. As mentioned earlier, many of the children and youth identified under the state definition are receiving special education services in the schools.

3. Legislation, Litigation, Advocacy, and Funding Mechanisms

Federal and state legislation, as well as litigation involving services to children and the advocacy of political groups provide authorization and impetus for interagency service delivery, whereas federal, state, and private agencies and programs are sources of funding for planning and implementation of projects. Thus, an understanding of relevant laws, responses to litigation, actions of advocacy groups, grant programs, and funding opportunities may facilitate interagency program development.

Federal and State Legislation

Chapter 1 examined historical background factors and highlighted prior legislation. Here we focus on recent legislation that enables the creation of interagency community-based services for EBD children and their families. However, we wish to note that legislative efforts in the past decade established a public climate favoring a return to community-based human services. Specifically, Public Law 96–272, the Adoption Amendments and Child Welfare Act of 1980, established a federal priority on intensified programs to support families (as opposed to the creation of alternatives to natural family living environments). This priority was based on the observation that expensive alternative treatment programs have been no more successful, and often less so, than programs that support the natural families of targeted children (L. C. Wolfe, personal communication, February, 1991). Two amendments of the Education of the Handicapped Act (EHA) extended the thrust of Public Law 94–142 considerably. Public Law 98–199, the EHA Reauthorization of 1983, established priorities on related services and a focus on parents of children with disabilities. The 1986 amendments (Public Law 99–457) added a state formula grant program to assist in the provision of early intervention services for infants and toddlers with disabilities and their families (Thomas & Bunsen, 1990). Furthermore, this law established transition as a priority area. Attempts to implement systematic transition procedures for students with disabilities increased the need for interagency communication and collaboration where previously there had been none (Edgar, Webb, & Maddox, 1987).

In 1984 Congress funded an initiative to demonstrate the development of better functioning service systems for children and youth with mental health problems. This effort led the National Institute of Mental Health to create CASSP. The CASSP program supports states in the development of interagency efforts to improve the systems under which the most troubled children and adolescents receive services (Stroul & Friedman, 1986).

Title V of Public Law 99–660, entitled "State Comprehensive Mental Health Service Plans" established the mandate necessary to direct planners and policymakers toward community-based interagency services for individuals affected by mental illness. This bill requires that states develop a balanced system of care that encompasses a full range of community-based service options for adults with mental illness. However, states and communities have moved toward the creation of similar systems for children and adolescents with SED and their families (Department of Health and Human Services, Public Health Service, 1991). Further, as we mentioned above, the legislation authorized federal grants to assist in planning such programs and made federal technical assistance available to states requesting such services. Its most recent amendments (Public Law 101–639) mandate state plans for SED children as well. Public Law 99–660 and its amendments, as well as the Public Health Service Act and its amendments (Public Law 101–93), have been the major foundation of the CASSP Research and Demonstration Projects (see below).

Legislation currently is being considered by both the House (House of Representatives 497) and Senate (Senate Bill 924) to create a new federal grant program focusing exclusively on the needs of children with serious emotional, behavioral, or mental disorders. If enacted, this legislation, "The Children's and Communities' Mental Health Systems Improvement Act of 1991," will provide 100 million dollars in block grants in fiscal year 1992 (and up to 300 million dollars in 1994) to enable states to develop local systems of care through collaborative efforts of mental health, child welfare, education, and other appropriate agencies. States would provide a broad range of services for children under the age of 21. Each client would have an individualized service plan and a designated case manager (S. Forness, personal communication, July, 1991; *Legislative Alert*, May 3, 1991).

A number of states have responded to the federal government's call for statewide plans for SED children and youth. Some states have anticipated the mandate for such plans by passing legislation requiring children's services. For example, Kentucky has developed a program called Kentucky IMPACT (Interagency Mobilization for Progress in Adolescent and Children's Treatment). This program was enabled by state legislation

(House Bill 838, 1990) that mandates interagency planning for community-based services to children and youth defined as SED in the state plan. The legislation created a State Interagency Council (SIAC) for Services to Emotionally Disturbed Children, composed of the administrators of state human resource agencies. Also created were Regional Interagency Councils (RIACs), composed of regional administrators in each area development district and major metropolitan center. The SIAC reviews the need for services to SED children and adolescents and the delivery of those services; makes recommendations to the governor and state legislature; advises, supervises, and evaluates the RIACs; develops interagency agreements as necessary; and creates service programs to meet the needs of SED children. Each RIAC performs similar functions on the regional level. In addition, RIACs review children's case histories and coordinate services, advise the SIAC regarding the delivery of services within the region, and refers those children who cannot be served within the region to the SIAC. A copy of House Bill 838 is included as Appendix A. (See page 87.)

Kentucky also enacted legislation that initiated a major reform in the state's public education system. House Bill 940, the Kentucky Education Reform Act (KERA) of 1990, includes two mandated programs that have major implications for interagency services. First, it establishes Family Resource Centers, to be located in or near each elementary school in which 20% of more of the student body are eligible for free school meals. The plan developed for Family Resource Centers will promote the identification and coordination of existing resources and will include, but not be limited to, the following services:

- Full-time preschool child care for 2- and 3-year-olds
- After school child care for children 4 through 12 years of age
- Full-time child care for children ages 4 through 12 years old during the summer and on other days when school is not in session
- Families in Training (an integrated approach to home visits, group meetings, and monitoring of child development for new and expectant parents)
- Parent and Child Education (PACE)
- Support and training for child day care providers
- Health services, referral to health services, or both

Second, House Bill 940 establishes Youth Service Centers in or near each school serving children and youth age 12 and older in which 20% or more of the student body are eligible for free school meals. The plan for these centers will promote the identification and coordination of existing resources and will include, but not be limited to, the following services:

- Referrals to health and social services
- Employment counseling, training, and placement
- Summer and part-time job development

- Drug and alcohol abuse counseling
- Family crisis and mental health counseling

The KERA specifies that a 5-year implementation plan be developed, with one fourth of the Family Resource Centers and Youth Service Centers to be developed by June 30, 1992, and the number of centers increasing by one fourth each year thereafter. Nine million dollars has been set aside in the 1992 fiscal year to fund proposals received by school districts.

These centers will address the needs of many children and youth at risk for developing EBD, and their families. Moreover, they will be a vehicle for interagency planning and service delivery. Since the majority of children are in school on any given week day, locating interagency activities in or close to schools is both logical and functional.

The most recent amendment of the EHA, the Individuals with Disabilities Education Act (IDEA) of 1990 (Public Law 101-476), inaugurated a number of important changes in this landmark legislation. Those that have the most direct implications for community-based interagency programming for EBD children and youth include: (a) the creation of autism as a separate category of disability; (b) the addition of rehabilitation counseling and social work services as related services in the law; (c) the addition of a definition of transition services to students' post-school environments, and; (d) the introduction of the concept of multiple transitions, in recognition that children with disabilities may face many such transitions during their school years (e.g., from medical care to special education, between residential and community-based placements). When promulgated by changes in the federal regulations and subsequent alterations in the priorities of federal funding agencies (e.g., the Office of Special Education Programs) these modifications will provide stronger support for special education programs that have functional links to community services.

An even more important provision of Public Law 101-476, in terms of potential impact on children and adolescents with EBD, is the establishment of a new program of support for projects to improve special education and related services for these students. Projects may include the development and demonstration of strategies to reduce the use of out-of-community residential programs and to increase the use of school district-based programs, the development of effective collaboration among educators, related services personnel and others, and the design and demonstration of innovative approaches to prevent children with emotional and behavioral problems from developing serious emotional disturbance. The legislation also authorizes grants to local education agencies, in collaboration with mental health agencies, which target the following changes in services to pupils with EBD to:

- Increase the availability, access, and quality of community services

- Improve working relations among education, community mental health and other personnel, families and their advocates
- Target resources to school settings (e.,g., providing access to school and/or community mental health and other resources to students who are in community school settings)
- Address the needs of minority children (National Association of State Directors of Special Education, 1990, p. 13).

Thus, the stage has been set by federal and state policymakers for the introduction of new directions and concepts in caring for children and youth with EBD.

Response to Litigation

In 1979, what some regard as "the most significant litigation in this century on behalf of children" (Behar, 1990, p. 132) occurred when a suit was brought against the state of North Carolina for its failure to provide appropriate treatment and education for institutionalized children, most of whom were SED. As Behar (1985; 1990) notes, it was the state's response to this litigation that was more remarkable than the lawsuit itself (*Willie M. et al., v. James B. Hunt, Jr. et al.*, 1983). North Carolina quickly agreed to provide a full continuum of community-based treatment services as an alternative to institutional care for these children and adolescents. With this continuum in place statewide, North Carolina is able to provide the structure and supervision for, as well as 24-hour implementation of treatment plans for, more than 99% of its 1,200 identified children without using hospital care. The state provides financing for the continuum, about $25,000 per year on each child, which, while significant, is considerably less than the cost of psychiatric hospitalization or other types of residential care (Behar, 1990). The Willie M. case has enormous implications for other states that are struggling under the dual burdens of parents who demand services for their children and the astronomical costs to public agencies imposed by private psychiatric hospitals.

More recent litigation in other states has had similar impact. For example, a 2½-year-old federal lawsuit challenging services to emotionally disturbed foster children in Alabama's foster care system (*C. R. v. Hornsby*, 1991) has recently been settled out of court. This settlement, affecting an estimated 2,600 children, provides a model for systems throughout the country by establishing "operating principles" and standards to govern the state's child welfare activities, whereas settlements in other states (e.g., Massachusetts, New Mexico, Connecticut, Missouri, and Maryland) specify quantative measures, such as caseloads and timelines. Evidence gathered by the plaintiffs demonstrated that Alabama's system was crisis-oriented and reactive, resulting in the unnecessary foster placement of many children. The settlement is designed to create a system of care focused on the prevention of out-of-home placements, family reunification, and permanency. It also emphasizes services that are driven by the needs of children with emotional and behavioral problems (Jackson, 1991). A recent complaint filed in U. S. District Court for the District of Arizona (*Josh L. v. Symington*, 1991) alleges that children with disabilities are not properly identified, located, or evaluated, including those in detention and those who are incarcerated. In addition, the complaint alleges that children with disabilities are denied mental or behavioral health treatment and care and are inappropriately placed in the custody of the state either awaiting disposition to the Arizona Department of Juvenile Corrections or held in county juvenile detention facilities. Children who are SED are preselected as "behavioral problems" and are incarcerated (P. Leone, personal communication, August, 1991).

Cases such as these reveal the scale of inadequate and inappropriate services to troubled children in youth, and expose the discrepancies between their needs and the services they receive. Fortunately, the creation of new state and federal laws is establishing a legal mandate for appropriate services in least restrictive settings that no longer can be denied.

The National Special Education and Mental Health Coalition

This coalition is not a legislative body, but it has provided vigorous advocacy for coordinated treatment planning and services to children and youth whose problems require extensive family and community support services in addition to special education. In addition, the coalition has produced a draft statement of the major problems in the area of EBD and has begun to formulate an action plan calling on teachers, mental health professionals, advocacy groups, and professional associations to support efforts on behalf of these children and youth (Forness, 1988). At this writing, membership is comprised of over 30 diverse organizations, including the:

- American Academy of Child and Adolescent Psychiatry
- American Association of Children's Residential Centers
- American Psychological Association
- Council for Children with Behavioral Disorders
- Council for Exceptional Children
- Education Law Center
- Florida Research and Training Center
- Mental Health Law Project
- National Alliance for the Mentally Ill
- National Association of School Psychologists

- National Association of Social Workers
- National Association of State Directors of Special Education
- National Association of State Mental Health Program Directors
- National Information Center for Handicapped Children and Youth
- National Mental Health Association
- State Mental Health Representatives for Children and Youth (Forness, 1988, p. 128).

As mentioned in Chapter 2, the coalition is responsible for drafting the proposed new federal definition of EBD. It also has lobbied for federal children's mental health legislation, the development of community-based children's service programs, individual service plans, and an amendment to the social security laws to include mental health needs as one of the eligibility requirements for children under Medicaid (S. Forness, personal communication, March, 1991).

Grant Programs and Funding Mechanisms

A number of funding opportunities exist for interagency planners and program developers. However, because funding priorities of various granting agencies, both public and private, change frequently, the information presented here should be regarded primarily as illustrative. Agency contacts, who can provide current program announcements, are provided in Appendix B on page 93.

Federal Agencies

Several departments of the federal government operate active grant and contract programs supporting human services projects. As noted earlier, a shift in federal policy has increased the receptiveness of these agencies to proposals with a focus on community-based interagency services. The U.S. Department of Education operates a broad spectrum of grant programs through a number of offices, including the Office of Special Education and Rehabilitative Services, the Office of Elementary and Secondary Education, the Office of Bilingual Education and Minority Languages Affairs, and the Office of Educational Research and Improvement. Many of these programs sponsor research and demonstration projects that focus on families and communities. Specifically, the Office of Special Education and Rehabilitation services recently identified SED as a research and training priority in its discretionary grant programs.

Other federal agencies, such as the Department of Health and Human Services and the Department of Justice, Office of Juvenile Justice and Delinquency Prevention, sponsor projects that focus on specific issues such as family violence, gangs, and delinquency prevention. Many of these programs support interdisciplinary efforts. For example, the Department of Health and Human Services recently sponsored a competition for community-based projects to address precriminal and criminal youth. Operating under the Department of Health and Human Services, the National Institute of Mental Health, through its Department of Human Services, offers a variety of programs that address child, family, and community needs. Perhaps the most important program, in terms of the purposes of this book, is the CASSP Research and Demonstration Projects. Through a series of state grants, for several years CASSP has been promoting both concepts and strategies for changing the service system in order to more responsibly meet the multiple needs of children and youth with emotional and behavioral problems (Stroul & Friedman, 1986). These activities have included: (a) setting goals for state grants; (b) introducing special initiatives, such as training, technical assistance, national and regional conferences, and state networking meetings; (c) piggybacking on existing and new legislation; and (d) stimulating research, development, and the dissemination of information (Jacobs, 1990). The target populations for these grant projects include children and youth with SED, as well as those who are at risk for serious emotional or mental disorders, including:

- Those who are homeless, either as part of a family unit or alone, including runaway youth
- Those with a family history of severe mental illness
- Those living with parents who are unable to provide adequate care and nurturance, including drug-addicted parents
- Those who are victims of violence
- Those who are substance abusers
- Those who are HIV-infected youth
- Those who have sustained closed head injuries
- Those with multiple problems (e.g., school dropouts or pregnant teenagers)

(Department of Health and Human Services, Public Health Service, 1991, p. 2).

Some of the issues listed in a current program announcement are: investigations of the effectiveness of alternative models to community-based systems of care; assessments of the financial, social, and emotional impact of alternative approaches; investigations of the relative efficacy of innovative service approaches; studies of the impact of specific laws and regulations, and of different organizational patterns; studies of the effectiveness of new models of interagency collaboration and service integration; studies of the relative efficacy of different family support approaches, and research concerning the nature, role, and effectiveness of services by nontraditional providers (e.g., street workers, runaway services) (Department of Health and Human Services, Public Health Service, 1991). Eligibility for grant awards is restricted to state mental health authorities, other state agencies in which the statewide responsibility for child mental health resides, or other state child services coordinating organizations as designated by the governor. This restriction is in keeping with CASSP's focus on promoting the development of state plans for comprehensive systems of care (Stroul & Friedman, 1986).

Notices regarding program announcements and requests for proposals may be obtained from the *Federal Register*, bulletins and newsletters such as the *Federal Grants and Contracts Weekly*, and electronic mail bulletin boards (e.g., SpecialNet). Professional organizations often maintain advocacy and governmental relations standing committees that keep their memberships informed of policy issues, priorities, and federal programs. Specific resource information is provided in Appendix B on page 93.

Private Funding Agencies

A number of private foundations support projects addressing mental health issues. One specific program will be described here, because of its focus on the issues and population of concern to this book. The Robert Wood Johnson Foundation Child Mental Health Initiative, established in 1988, has sponsored planning and demonstration projects in several states and communities to meet the needs of EBD children and their families.

The program has provided $20.4 million during a 4-year demonstration period, addressing two basic goals: to develop programs to serve children outside hospitals; and to create a restructuring of the financing mechanisms in the participating states (Behar, 1990). In 1989, planning grants were awarded to 12 projects. Eight projects received implementation funding in 1990. These included Cleveland, Ohio; Madison, Wisconsin; Delaware County, Pennsylvania; Multnomah County, Oregon; San Francisco County, California; Western North Carolina; Central Kentucky; and the entire state of Vermont. The central Kentucky project (Bluegrass IMPACT) is highlighted in Chapter 7. Since private agency funding programs are diverse and frequently localized, interagency planners are advised to consult their own information networks regarding programs available in their areas.

Funding Base for Kentucky IMPACT

Kentucky has experienced the same set of problems as many states with regard to excessive hospitalization of children and youth with EBD, costly placement of these children in out-of-district educational programs, and high Medicaid expenditures. An overview of the Kentucky SED plan (Kentucky IMPACT) is provided here to illustrate the type of planning, development, and creative funding that is needed to establish comprehensive interagency services for this population.

Responsibility for Kentucky's Comprehensive Mental Health Services Plan, which embraces a full range of mental health, mental retardation, and substance abuse services to both children and adults, is invested in the Department for Mental Health and Mental Retardation Services (DMHMRS) under the auspices of the Cabinet for Human Resources (CHR). CHR is Kentucky's umbrella agency for health, social services, mental health, and economic security programs. Local mental health and mental retardation services are administered through 14 regional community mental health and mental retardation boards, which operate local community mental health centers.

The DMHMRS was created by the reorganization of the Department of Mental Health in 1984. A year later, the Children and Youth Services Branch (CYSB) was established. In 1988, Kentucky contracted with NIMH to prepare a "Comprehensive Mental Health System Plan" under the terms and conditions of the Comprehensive Mental Health Service Act (Public Law 99–660). Toward the end of that year, a statewide Comprehensive Mental Health Planning Symposium was held. Participants' recommendations formed the basis of the strategies in the first year's plan (January, 1989). During this period the CHR established a Mental Health Services Planning Council to serve as an advocate for adults and children with mental health problems (Kentucky Cabinet for Human Resources, 1990).

Specific planning for children and youth with SED was facilitated by a CASSP grant from NIMH in 1985. This grant provided funding for three new DMHMRS staff members and served as a catalyst for the development of a system of care through increased funding, training, services, interagency collaboration, and parent participation. Currently, the CYSB includes nine staff members and an ongoing CASSP initiative. Through the designation of children's services coordinators at each of the 14 CMHCs, community-based service development and improved communications within regions and across the state on behalf of children has been accomplished (Kentucky Cabinet for Human Resources, 1990).

A new plan to address the mental health needs of Kentucky's children with SED (Kentucky IMPACT) was developed, approved, and funded for fiscal year 1991–92 by the 1990 Kentucky General Assembly and is being implemented throughout the state. This plan established the State Interagency Advisory Council, as well as seven components for statewide services to children:

1. Staffing for a local interagency council in each region;
2. At least one service coordinator (case manager) in each region;
3. Wraparound funding (intensive family-based support services) to pay for services (not otherwise available) based on the individual needs of children;

4. Family preservation programs;
5. Purchase of services for children in private child care;
6. Nonhospital psychiatric residential treatment facilities; and
7. Intensive in-home services

(Kentucky Cabinet for Human Resources, 1990).

These seven services will be jointly funded by new monies allocated to DMHMRS, the Department for Social Services, and the Department for Medicaid Services. In fiscal year '91, $5,066,000 is allocated to serve an estimated 1,428 children. For fiscal year 1992–93, $7,577,000 has been allocated to serve an estimated 3,134 children. In 1990, Kentucky received a $2.4 million 5-year implementation grant from the Robert Wood Johnson Foundation. As mentioned earlier, this project (Bluegrass IMPACT) serves the central Kentucky region. It is the model for implementation of the Kentucky SED plan (Kentucky IMPACT).

Several special demonstration projects for children also have been funded through federal block grant money, funds diverted from state mental hospitals for adults, and a CASSP project in one mental health region. Collaborative efforts with the Kentucky Department for Social Services and the Kentucky Department of Education include the development of flexibly funded, individually tailored, child- and family-based service contracts (referred to as "wraparound" services), intensive in-home services, therapeutic foster care initiatives, supports to day-care providers, the identification of EBD children by school systems, preschool assessment training, and the expansion of day treatment and other school-based programs. The DMHMRS also has been working with the Department of Medicaid Services to ensure that reimbursement mechanisms encourage the mental health and support services needed by children and their families. Medicaid now covers home visits, off-site services at a school or day-care center, and face-to-face collateral services on behalf of children when these services are provided by mental health center staff in conjunction with an individualized plan of care. Medicaid also covers case management and intensive in-home services; by 1992 it will cover nonhospital residential services (Kentucky Cabinet for Human Resources, 1990). This blended funding strategy yielded a funding pool of $6,120,900 for fiscal year '91 and $12,717,400 for fiscal year '92.

This diverse and flexible funding policy has been driven by a principle that is the essence of successful interagency planning:

> Federal and state funds should follow the child instead of the child following the funding in order to obtain services. A plan of treatment should meet the child's individualized needs rather than adapting the treatment to the constraints of the funding sources, whether public or private. The community should be cultivated as a rich

source of services as well as funds (Kentucky Cabinet for Human Resources, 1990).

Although funds come to agencies through customary bureaucratic channels, flexibility in their use is the key to providing programs that meet children's and families' complex functional needs. Through the unselfish foresight and aggressive efforts of state, regional, and local leaders, as well as the invaluable technical assistance of CASSP staff, Kentucky is developing a children's services mental health delivery system that is based on clients' needs in their least restrictive settings at a reasonable cost to taxpayers.

Thus, the new decade has brought new responsibilities and challenges for agencies providing services to children with EBD and their families. Whereas in the past, agencies operated in isolation and with relative autonomy, contemporary legislative mandates and best practices require collaborative planning and service delivery. The goal is a system of care that provides support for affected children and their families in the least restrictive treatment and educational environments. The strategy for achieving this goal is to establish a full continuum of services that can be flexibly arranged to each client's individual needs.

4. Professional Roles and Conceptual Models

Misunderstanding regarding the perspectives of other professionals and how these perspectives translate into service delivery is a major barrier to effective interagency communication and collaboration (Edgar et al., 1987). Conversely, knowledge of the roles and views of human service professionals, and of their contributions to meeting clients' needs may help to avoid conflict and to facilitate interagency cooperation. In this chapter we describe two processes that influence the roles of professionals in collaborative working situations, followed by brief descriptions of the dominant conceptual models influencing the study and treatment of emotional and behavioral disorders. Next, we review the evolution of conceptual models describing the ways in which multiple disciplines interact in delivering services to an individual client. The chapter concludes with a presentation of Stroul and Friedman's (1986) system of care, which has become the leading model for designing approaches to community-based interagency services for EBD children.

Interagency Professional Roles

The **collaborative consultation process** (Idol, Paolucci-Whitcomb, & Nevin, 1986), in which a student's needs are addressed through consultative assistance to his or her teacher by a trained specialist, has created a role for professionals who interact across disciplines. Traditionally, special educators, regular educators, school psychologists, guidance counselors, and other school personnel have been given responsibility for delivering school-based consultative services. Collaborative consultation has occurred primarily in the schools and has focused on educators serving other educators; nevertheless, the legitimization of consultation as an educational service has provided many professionals with awareness of and training in this new role. Furthermore, experimentation with a greater variety of consultative models (e.g., Morsink, Thomas, & Correa, 1991; Phillips & McCullough, 1990) has facilitated the involvement of other professionals in providing collaborative consultation to the teachers of students with disabilities. As interagency collaboration becomes a more routine facet of serving pupils with EBD as well as with other disabilities, professionals from other disciplines will have more active roles in interactive team planning for students both in and out of school (Morsink et al., 1991).

The list of persons who may be involved in the delivery of services to EBD children and their families includes professionals from the fields of general and special education, school and clinical psychology, social work, psychiatry, neurology, pediatrics, speech and language therapy, physical therapy, occupational therapy, recreational therapy, juvenile justice, and vocational rehabilitation. These persons may provide consultation or deliver direct services in the implementation of treatment plans for individual clients. Unfortunately, these specialists often not only are unaware of the activities of other professionals who may be working on the same case, but also frequently work at cross-purposes unless someone coordinates the services being received by the client (Johnson, 1989).

The role of **case manager** has been created to serve this important function. Working from the interagency treatment plan, the case manager has four major responsibilities: (a) coordinating the services needed by the client and family; (b) delegating responsibility for providing these services to the professionals who are best able to provide them; (c) providing follow-up to ensure that goals are being met; and (d) guiding the work of paraprofessionals and volunteers who assist on the case (Morsink et al., 1991). The case manager should be able to work with a variety of professionals including police, probation officers, juvenile and family court judges, school and medical personnel, providers of various support services, and the child's primary treatment agents (Johnson, 1989).

Conceptual Models

Awareness and understanding of specific disciplinary contributions to meeting client's needs is not the responsibility of the case manager alone. All professionals must learn about one another's perspectives if they are to collaborate effectively. Individuals from various disciplines often are significantly influenced by the dominant model of psychopathology embraced by their discipline or by the majority of professionals in it. These belief systems frame professionals' responses to problems experienced by children and their families, to schools and other agencies that serve children and families, and to the communities in which they work. Personal belief systems are associated with the conceptual model embraced by a professional or his or her discipline, and serve to frame his or her view of the nature of the problem, legitimate means of investigating the problem, and the process of collaboration with other professionals (P. Leone, personal communication, August, 19[illegible]

Historically, the preponderance of conceptual models have taken microlevel perspectives, in that the child is seen as the source of the problem, and interventions are directed toward correcting problems inherent in the child (Leone, 1990). Among these perspectives, the **medical model** of course influences most medical practitioners. This model assumes that biophysical causes underlie behavioral symptoms, and that eventually a specific cause of the child's disorder will be found, such as a faulty gene or clustering of genes that leads to a biochemical abnormality. This model engages clinicians in the study of the disorder's etiology, pathogenesis, signs, symptoms, diagnosis, and treatment. The physician elicits the history of the child, searching for a group of symptoms consistent with the current diagnostic criteria (e.g., DSM-III-R). Once the diagnosis is made, treatment usually consists of some type of psychotropic medication as the primary intervention, although some physicians combine pharmacology with parent counseling or psychotherapy and recommend intensive school-based interventions (Singh, Parmelee, Sood, & Katz, in press).

Another microlevel perspective is the **psychodynamic model**, which has influenced the disciplines of psychiatry, psychology, social work, and education for many years. Derived from psychoanalytic theory, this model views emotional and behavioral disorders as manifestations of an imbalance among the dynamic parts of one's personality (i.e., the id, ego, and superego). The child's disorder is symptomatic of an underlying psychopathology, caused by excessive restriction or gratification of the child's instincts at a crucial stage of personality development or by early traumatic experiences. (Kauffman, 1989). Treatment consists of a combination of individual psychotherapy, child therapy, and parent guidance, with the goal of addressing the underlying conflict (Kauffman, 1989; Singh et al., in press).

Another microlevel perspective, the **behavioral model**, has exerted strong contemporary influence on all of the disciplines mentioned above. In contrast to the psychodynamic model, the behavioral model focuses on the behavior itself, and emphasizes the role of learning, through influential antecedent and consequent events, in the genesis of maladaptive behavior patterns (Kauffman, 1989; Kerr & Nelson, 1989). Functional analyses of targeted behaviors and their relationship to specific antecedent and consequent stimuli is critical to effective assessment and treatment planning. Interventions consist of systematic and continuous measurement of targeted behaviors while manipulating antecedent and consequent events until reliable changes are accomplished in these behaviors (Kauffman, 1989).

On the other hand, the **ecological model** considers an individual's behavior in relation to more general behavioral or social systems in his or her environment. Emphasis is placed on understanding behavior in the natural environment, focusing on the delineation of laws relating behavior and patterns of interaction to changing aspects of that environment (Dadds, 1987). The client is considered to be enmeshed in a complex social system, both as a giver and a receiver in social transitions with significant others in a variety of settings. Because the ecological model stresses the interactions between individuals and their environments, it assumes a mesolevel perspective (Leone, 1990). Interventions are directed toward all facets of the client's milieu, but they have tended to emphasize strategies derived from the behavioral model (Kauffman, 1989).

These models have dominated discipline-specific research and treatment modalities, leading in varying degrees to conceptual and professional polarization, which has been detrimental to client progress (Singh et al., in press). Increasingly, scholars have advocated for an integrated approach that takes into account the continuous, reciprocal, and interdependent interactions between the child, his or her internal states, and the social systems and persons in the environment, not just immediate antecedents and consequences (Bijou & Baer, 1978; Singh et al., in press). Singh et al. (in press) define this approach as the **ecobehavioral model** and point out that an important assumption of this model is that any one professional, regardless of discipline, can serve as the primary therapist or case manager. The major requirement of this role is that the case manager must be able to coordinate the duties of the different team members and to effectively serve as a liaison with parents and professionals. This model eschews discipline-specific approaches to assessment and treatment in favor of multimethod approaches, and provides a framework for synthesizing information from the different disciplines. For example, the initial assessment uses tools from various disciplines to construct a comprehensive database that addresses the history of the disorder, antecedents and consequences, previous treatments, the family and school situation, and other relevant variables thought to play a role in the child's behavior (Singh et al., in press).

Still another perspective is provided by macrolevel analysis, which focuses on institutional, cultural, and other social forces that give meaning to daily events and influence behavior (Leone, 1990). This model stresses that structural and cultural factors—such as poverty, unemployment, and the size and organization of social institutions such as schools—create, mitigate, or exacerbate problem behavior (P. Leone, personal communication, August, 1991). The focus of analysis and intervention in this perspective is on the structural deficits of society that include inadequate housing, less than livable wages, lack of universal health care, delinquent gangs, and widespread drug abuse (E. Edgar, personal communication, July, 1991; Edgar, 1990).

In relationship to interagency functioning, it is useful to understand the evolution of team approaches to dealing with client problems. With few exceptions, the historical pattern initially involved a **unidisciplinary team model**, where specialists representing each discipline involved with a client work in relative isolation and autonomy (Landerholm, 1990). The **multidisciplinary team model** was developed in the field of medicine (Morsink et al., 1991). This model is characterized by professionals from various disciplines who meet for diagnostic or planning purposes but still work independently with children or families, often in a segregated situation (Beck, Bartel, & Nelson, 1991). Both of these models create case management problems because too many specialists may offer conflicting views and advice to clients and parents (Landerholm, 1990). Morsink et al. (1991) differentiate between this approach and the **interdisciplinary team model** by observing that in the former, team members report information to a single leader while in the latter, team members evaluate the client and then meet as a group to discuss their findings. In common with the multidisciplinary approach, the interdisciplinary model is referenced to, and driven by, the orientations of the individual disciplines. Frequently, the ensuing competitive or individualistic professional interactions result in uncoordinated, inconsistent, or unintegrated services (Giangreco, York, & Rainforth, 1989).

The **transdisciplinary team model** was developed to reduce some of the fragmentation of services that often occurs in the implementation of multidisciplinary and interdisciplinary models (Hart, 1977; Morsink et al., 1991). This approach stresses the integration of both assessment information and treatment implementation. All major goals and treatment activities are driven by individual client's needs, in terms of long-term outcomes in least restrictive settings (Beck et al., 1991). This model also incorporates a joint approach to problem solving, in which it is assumed that the team shares collective responsibility for service delivery. The expertise of individual team members is used to train other team members; roles as well as responsibilities are shared by more than one team member (Lyon & Lyon, 1980). Morsink et al. (1991) incorporate this model in their interactive teaming approach, in which all team members have acquired competencies in collaborative consultation and team roles are shared through role release (sharing general information, informational skills, and performance competencies; Lyon & Lyon, 1980). Attention to group process is important to successful interactive teaming, including team building, the development of cooperative goal structures and a supportive climate, shared decision making, democratic situational leadership, and systematic procedures for conducting team business.

A System of Care

The system of care concept developed by Stroul and Friedman (1986) and adopted by CASSP has helped policymakers and agency practitioners avoid thinking primarily in linear terms.

> A system of care is a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of severely emotionally disturbed children and adolescents. (Stroul & Friedman, 1986, p. iv).

The notion of a continuum of services often is associated with services delivered along a series of placements that are progressively more restrictive for EBD children and youth. In contrast, the system of care perspective focuses on broadening and strengthening the community base as the essential arena for treatment and rehabilitation. Services in a system of care are modular, circular, overlapping, and interactive (Multiagency Network for Severely Emotionally Disturbed Children, 1989).

Two core values and a set of guiding principles form the basis of the system of care: First, the system of care should be child-centered, with the needs of the child and family dictating the types and mix of services provided; and second, the system of care should be community-based (Jacobs, 1990). The 10 principles of a system of care are presented in Table 4-1. Three principles are central: (a) that a comprehensive array of services addressing the child's physical, emotional, social, and educational needs is provided; (b) that services are provided in the least restrictive, most normative environment that is clinically appropriate; and (c) that services are integrated across child-serving agencies with case management or a similar mechanism delivered in a coordinated and therapeutic manner (Jacobs, 1990).

Jacobs (1990) lists services for EBD children and adolescents in two groups: those that are least restrictive and those that are most restrictive. Community-based care comprises the least restrictive category and includes:

- Prevention
- Early identification and intervention
- Assessment
- Outpatient care
- Home-based care
- Therapeutic group home care
- Therapeutic foster care

Most restrictive services consist of residentially-based care and include:

- Residential treatment center
- Inpatient hospitalization

Jacobs (1990) observes several weaknesses in relying upon more restrictive or "deep-end" services, which often are the only options available for EBD children and youth. At the one extreme is inpatient hospitalization, which removes the child from the home, community, and family, often cutting bonds and making successful reintegration after

TABLE 4-1
Principles of a System of Care

1. Emotionally disturbed children should have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs. Thus, the scope and array of services included in the system of care must be sufficiently broad to account for the diverse and multidimensional needs of the developing child.
2. Emotionally disturbed children should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan. The culmination of the assessment process should be an individualized service plan which identifies problems, establishes goals, and specifies appropriate interventions. The plan should be developed with the full participation of the child, family, providers, and significant others. Service goals and plans should be reassessed regularly and revised based on the dynamic nature of the strengths, weaknesses, and needs of the child and family. An ideal system of care allows the child opportunities to progress and to move to less restrictive settings as well as to use more intensive forms of services when indicated.
3. Emotionally disturbed children should receive services within the least restrictive, most normative environment that is clinically appropriate. An implicit goal of the system of care is to maintain as many children as possible in their own homes by providing a full range of family-focused services and support. Residential services should be employed only when more normative nonresidential options are not effective in meeting the therapeutic needs of the child and family. Residential services, when indicated, should be located as close as possible to the child's home in order to cause the least disruption of the child's link to family, friends, agencies, school, and community.
4. The families and surrogate families of emotionally disturbed children should be full participants in all aspects of the planning and delivery of services. Family needs often are neglected when children are in residential settings. By involving and providing supports to families, the opportunities for successful return of the child to the family are enhanced.
5. Emotionally disturbed children should receive services that are integrated, with linkages between child care agencies and programs and mechanisms for planning, developing, and coordinating services. Coordination, continuity, and movement within the system are critical for children who have multiple needs that cut across agency boundaries.
6. Emotionally disturbed children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs. Case management, therapeutic case advocacy, and a variety of similar approaches are intended to ensure that children and families receive the services they need, that services are coordinated, and that services are appropriate to their changing needs over time. The case manager coordinates the comprehensive interagency assessment of the child's needs; plans, arranges, and monitors needed services; links the various parts of the child's system; advocates for the child and family; and establishes links with the adult service system to facilitate transition. These functions are essential, unifying factors in service delivery.

Continued

TABLE 4-1 (continued)
Principles of a System of Care

7. Early identification and intervention for children with emotional problems should be promoted by the system of care in order to enhance the likelihood of positive outcomes. While there is increasing interest in screening and intervention programs to identify and assist high-risk children and families, these services are often neglected in favor of much needed services for children who already are demonstrating serious problems.
8. Emotionally disturbed children should be ensured smooth transitions to the adult service system as they reach maturity. Children who age out of the system of care become young adults who often are in need of long-term mental health care, vocational services, and a range of other support services.
9. The rights of emotionally disturbed children should be protected, and effective advocacy efforts for emotionally disturbed children and youth should be promoted.
10. Emotionally disturbed children should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

Source: From *A System of Care for Severely Emotionally Disturbed Children and Youth* by B. A. Stroul & R. M. Friedman, 1986, Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center. Reprinted by permission.

discharge difficult. Furthermore, prolonged hospitalization may produce an institutional dependency, thus failing to prepare the child for normal community living. At the other extreme is outpatient care, which also often fails to meet the child's needs, being too little and too removed from his or her daily life.

The CASSP system of care is organized around seven service dimensions: mental health, social, educational, health, vocational, recreational, and operational/case management. If services are to be integrated among these dimensions, open channels of communication, joint planning at the agency and individual levels, and mechanisms to share or pool funding must be accomplished (Jacobs, 1990).

This chapter has provided a brief review of the professional roles, models, and philosophical issues that impact interagency service planning and delivery for EBD children and their families. Perhaps the most important variable for success is development of an "interagency attitude" (Phillips, 1991); that is, an attitude that interagency collaboration not only is an appropriate way to approach service delivery, it is also essential. It is incumbent upon practitioners who participate on interagency teams to learn to work together. This is new ground for many professionals accustomed to the status and autonomy that come from working within their own disciplinary circles. Acquisition of an interagency attitude requires training, time, and dedication to the idea that interagency collaboration must, and will, be accomplished. Given that interdisciplinary training is rare or missing in most preservice disciplinary training programs, good collaborative efforts may have to be relearned in field situations as each new generation of trainees emerges (S. Forness, personal communication, July, 1991).

5. Implementation

Chapter 5 focuses on the organization of a system of care for EBD children and their families. We present a general framework to guide interagency planners, as well as strategies and guidelines for program development at the state and community levels. We draw heavily from Stroul and Friedman's (1986) explication of a comprehensive system of care for SED children and adolescents. Next, we provide more specific information regarding the process and the components of interagency planning and program development. Finally, we describe some of the problems and barriers encountered by interagency programs and illustrate remedial strategies.

Strategies for Developing a System of Care

Stroul and Friedman's (1986) technical assistance manual was developed to assist states and communities involved in CASSP-related initiatives. They observe that while each state or community will select change strategies for systems that are most appropriate for its particular environment and circumstances, the experiences of other systems change programs suggests that several types of strategies are most likely to have a broad impact: (a) planning and needs assessment; (b) modifying the mental health system; (c) interagency collaboration; (d) technical assistance and training; (e) constituency building; and (f) local system development. Stroul and Friedman suggest that, in order to develop effective systems of care, states and communities should select and implement strategies from each of these categories, varying the emphases, strategy types, and sequencing to conform with the unique characteristics of each set of circumstances. Their analyses of previous systems change programs revealed that states generally develop a "master plan" or blueprint, which establishes a framework for their system improvement initiatives.

Strategies for Planning and Needs Assessment

This set of strategies encompasses the basic steps taken to initiate the systems change process. The first step is to establish a focal point at the state level to initiate and coordinate needs assessment and system development activities. Generally, states either identify or establish an administrative unit within the state mental health agency. This unit, staffed by individuals with expertise in child mental health, serves as the focal point for CASSP-related activities (Stroul & Friedman, 1986). However, states may use other administrative models. Isaacs (1984) describes three basic approaches to coordinated service delivery. One is a consolidated children's agency that assumes direct responsibility for all children's services programs. This model is followed in the organizational structures of Connecticut, Delaware, and Rhode Island. Another approach is a quasi-consolidated agency, in which responsibility for children's mental health services is divided between the children's agency and the mental health agency, as in Florida, Kentucky, and New Hampshire. The third approach is to establish a formal coordinating mechanism, in which responsibility for service delivery rests with different agencies, although attempts are made to coordinate policy and planning. This model is followed in Georgia, Maine, Massachusetts, Missouri, Ohio, and South Carolina. The designation or establishment of an administrative mechanism is important not only for internal coordination but also for developing a state children's services plan (required by Public Law 101–639) and for receiving grant funds through such agencies as CASSP. Stroul and Friedman (1986) suggest the following steps in the planning process:

- Defining the target population
- Assessing the characteristics and service needs of the target population
- Defining the nature and components of the desired system of care
- Assessing available services and identifying service gaps and needs

Stroul and Friedman recommend that planning and needs assessment include broad professional and consumer participation, along with input and involvement from health and human service agencies, professional provider organizations, parent and family groups, and child advocacy groups. In some cases, task forces or committees are organized around a specific task or issue. Surveys and needs assessments are the vehicles used to describe the target population, their service needs, and the available resources. Stroul and Friedman (1986) provide a set of questions useful for conducting system assessments, presented as Figure 5-1. These assessment questions address the characteristics of an effective system regarding the development of a model, planning and decision making, and interagency relationships. While the level of interagency organization required to make desirable responses to these questions may seem overwhelming to states and communities approaching this task for the first time, CASSP provides extensive technical assistance with state and local planning.

An important part of the planning and needs assessment process consists of identifying the services and programs currently available and comparing these with those needed to establish a full continuum. Table 5-1 lists the components identified by Stroul and Friedman (1986) for each dimension contained in their system of care. Many, if not all, of these

FIGURE 5-1
System Assessment

System of Care Model

- An effective and responsive system should recognize the need for a range of services and should be based upon a specific model of a children's system of care.
  - ☐ Does a model of care for SED children and adolescents exist?
  - ☐ Does the model include a wide range of both nonresidential and residential services?
  - ☐ Are data available on the capacity of each component of the system and on the percentage of the children's mental health budget for each component?
  - ☐ Is there a reasonable balance in the system, with greater capacities in the less restrictive than in the more restrictive services, and a significant portion of the budget for nonresidential services?

Planning

- Part of the foundation is a carefully developed state plan.
  - ☐ Is there a clear state plan that has been developed to prevent and treat emotional disturbance in children?
  - ☐ Is the plan the result of interagency collaboration with participation and input from all relevant child-care agencies?
  - ☐ Has there been participation by providers, parents, advocates, and consumers?
  - ☐ Is there a requirement that communities and/or regions within the state develop their own plans for systems, and if so, do they receive technical assistance in formulating the plan?
  - ☐ Are community and regional plans closely reviewed with meaningful feedback?

Community-Based Nature of the System

- Services should be provided and managed on a community or regional level.
  - ☐ To what extent do state policies and practices promote community-based services and acceptance of responsibility by communities for serving SED children and adolescents?
  - ☐ Are fiscal incentives available?
  - ☐ What proportion of the children's mental health budget is controlled at the community versus the state level?
  - ☐ To what extent are decisions about a particular child made at the community or the state level?
  - ☐ Are there accountability procedures to maximize the likelihood that communities will develop effective systems?

Interagency Collaboration

- ☐ Are there formal mechanisms at the state and community levels to ensure interagency collaboration in planning and delivering services?
- ☐ Are there incentives and requirements at the state and community levels for agencies to work together?
- ☐ To what extent does joint funding of programs and services occur?

Coordination and Management

- An effective system must be well-managed, with close coordination of services and clear accountability
  - ☐ Is there a management structure that provides clear roles and responsibilities for agencies and clear accountability?

Continued

FIGURE 5-1 (continued)
System Assessment

- ☐ Are different components of the mental health dimension coordinated to promote rapid and easy movement from one service to another?
- ☐ Are there close linkages among child-care agencies and systems so that children can receive multiple services in a coordinated manner?
- ☐ Is there a clear locus of responsibility for insuring that children with multiple needs do receive services from all relevant agencies?

Treatment Decision Making

- There should be clearly articulated procedures for making decisions about children.
  - ☐ Is there a clearly articulated procedure for treatment and placement decision making?
  - ☐ Is there procedural consistency among agencies?
  - ☐ Do decisions involve multiagency and multidisciplinary input?
  - ☐ Are treatment and placement decisions made on a community level?
  - ☐ Are family members and children permitted to participate in decision making?
  - ☐ Is there a systematic follow-up or progress review after placement in restrictive settings?

Training and Technical Assistance

- ☐ Is there a training and technical assistance plan at the state and community levels?
- ☐ Is consultation regularly provided to key community planners and service providers?
- ☐ Is consultation regularly provided to state level planners and policymakers?
- ☐ Do key individuals receive regular opportunities for training?
- ☐ Are adequate training and technical assistance provided before new services are initiated and at regular intervals?
- ☐ Is information about successful procedures and programs regularly and systematically disseminated throughout the state?

Advocacy and Community Education

- ☐ Are regular attempts made to educate the community?
- ☐ Are there attempts to involve parents, advocacy, civic, professional, and other relevant groups?
- ☐ Do public officials and representatives of parent, advocacy, civic, and professional groups work in partnership on behalf of children?
- ☐ Are there efforts to encourage the development of new advocacy groups and efforts to facilitate the advocacy actions of existing groups?

Standards, Monitoring, and Evaluation

- ☐ Are there guidelines and standards for programs and services?
- ☐ Are there guidelines and standards for community-based decision making and planning?
- ☐ Is there regular and periodic monitoring of adherence to standards with constructive feedback and requirements that deficiencies be remediated?
- ☐ Are there regular procedures for evaluating the outcomes and costs of systems, programs, and services?
- ☐ Are the results of these evaluations used as part of the planning and policy-making process?

Continued

FIGURE 5-1 (continued)
System Assessment

Statutory Base

☐ Is there an adequate statutory base for the provision of services?
☐ Is there an adequate statutory base for protection of the rights of children, particularly with respect to involuntary hospitalization, treatment in the least restrictive setting, and placements on units with adults?
☐ Do these protections include children served by both public and private sectors?
☐ Are there mechanisms for monitoring compliance with statutes?

Fiscal Policy

☐ Is there a secure and stable funding base for services?
☐ Do funding mechanisms provide adequate accountability and quality control while allowing providers flexibility in providing effective services?
☐ Do fiscal policies encourage an adequate balance between attention to immediate needs to provide services and to more long-range system needs to prevent serious emotional disturbance?
☐ Are multiple sources of funding (federal, state, local, and private) used?
☐ Are there incentives for muitiagency funding and creative interagency approaches to financing?

Source: From *A System of Care For Severely Emotionally Disturbed Children and Youth* by B. A. Stroul & R. M. Friedman, 1986, Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center. Reprinted by permission.

services are available in a given state. The task for planners is to determine the availability of services in each geographic region targeted for system impact and to design strategies for increasing their access by consumers. Given the likelihood that gaps in the continuum will exist in any given geographic service area, planners should compare existing services to a projected continuum after systems change has been accomplished. When doing this, they should bear in mind that services in the midrange of the continuum are likely to be in short supply (Behar, 1990), and that more services should be available at the less restrictive (community-based) end than at the more restrictive (residential) end (Stroul & Friedman, 1986). Behar (1990) presents a comparison of the present availability of mental health services with a proposed continuum, represented in Table 5-2. Comparisons of the specific services needed to those presently available, in conjunction with assessments of client characteristics and needs, will help planners accurately identify targets for change.

Strategies to Modify the Mental Health System

This set of strategies includes specific steps that may be taken to address the reforms needed for mental health agencies to promote system of care development. The goal of these strategies is to shift the philosophy, policies, practices, and resources of the mental health system to promote community-based, child-centered systems of care. One set of strategies

TABLE 5-1
Components of a System of Care

1. **Mental Health Services**
   - Prevention
   - Early identification and intervention
   - Assessment
   - Outpatient treatment
   - Home-based services
   - Day treatment
   - Emergency services
   - Therapeutic foster care
   - Therapeutic group care
   - Therapeutic camp services
   - Independent living services
   - Residential treatment services
   - Crisis residential services
   - Inpatient hospitalization
2. **Social Services**
   - Protective services
   - Financial assistance
   - Home aid services
   - Respite services
   - Foster care
   - Adoption
3. **Educational Services**
   - Assessment and planning
   - Resource rooms
   - Self-contained special education
   - Special schools
   - Homebound instruction
   - Residential schools
   - Alternative programs
4. **Health Services**
   - Health education and prevention
   - Screening and assessment
   - Primary care
   - Acute care
   - Long-term care
5. **Vocational Services**
   - Career education
   - Vocational assessment
   - Job survival skills training
   - Vocational skills training
   - Work experiences
   - Job finding, placement, and retention services
   - Supported employment

Continued

TABLE 5-1 (continued)
Components of a System of Care

6. **Recreational Services**
   - Relationships with significant others
   - After-school programs
   - Summer camps
   - Special recreation projects
7. **Operational Services**
   - Case management
   - Self-help and support groups
   - Advocacy
   - Transportation
   - Legal services
   - Volunteer programs

Source: From *A System of Care for Severely Emotionally Disturbed Children and Youth* by B. A. Stroul & R. M. Friedman, 1986, Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center. Reprinted by permission.

consists of developing or participating in the development of program or staffing guidelines and standards for system of care components. States may also focus on revising the rules and regulations governing state funding of mental health services to make systems of care for children a top funding priority (Stroul & Friedman, 1986).

Strategies that impact the legislative process can include drafting and submitting bills for system of care components and consulting with legislators and legislative committees regarding the needs of the target population. Other strategies include persuasive techniques to influence the budget preparation process within the mental health department, or its equivalent, as well as the preparation of special legislative budget issues and packages. Alternate strategies may attempt to access new monies or pursue the reallocation of resources for the development of more appropriate, community-based children's services. Suggested strategies to influence the development of new services, programs, or mechanisms at the community level include asking county boards or commissions to institute regulatory or budgetary changes that encourage the creation of system components and of multiagency service networks (Stroul & Friedman, 1986).

Strategies for Interagency Collaboration

These measures include educating other agencies about the needs of EBD children and youth, advocating for the target population in an attempt to recruit other agencies into the system, sharing resources among health and human service agencies, and creating a network of agencies committed to addressing the needs of this population. Planners should be

TABLE 5-2
Comparison of Services

Services	*Current System*	*Proposed System*
Hospitalization	•	•
Residential treatment		
Large setting	•	•
Group home		•
Professional parenting, specialized foster care		•
Supervised independent living		•
Day treatment		
High management—full day		•
Moderate management—full day		•
Moderate management with public school—half day		•
Therapeutic vocational placement		•
Therapeutic preschool (ages 0–6)		•
Evening treatment		
After school or work—half day equivalent		•
Therapeutic camping		
Weekend, summer, or year round		•
Outpatient		
Individual treatment (office or home)	•	•
Family treatment (office or home)	•	•
In-school support services		•
Emergency services (available 24 hrs./day)	•	•
Family preservation		
In-home crisis stabilization	•	•

Source: "Financing mental health services for children and adolescents," by L. Behar (p. 129). *Bulletin of the Menninger Clinic*, Vol. 54, pp. 127–139. Copyright 1990, The Menninger Foundation, Topeka, KS. Reprinted by permission.

prepared to organize, serve on, or consult with a wide array of interagency task forces and committees. Some of these groups may be initiated by the state legislature or the governor, while other interagency task forces may be a staff initiative. The success of interagency task forces depends on obtaining representatives at the right level (those with access to power, but close enough to affect operations), ensuring that tasks and roles are meaningful, and providing evidence that recommendations are taken seriously (Stroul & Friedman, 1986).

At the community level, the major strategy is to create a network of agencies to collectively address the system of care. This interagency network can serve as the focal point for local planning efforts for the system and can provide system level coordination of services. Interagency or interprogram agreements often are used to induce agencies to be collectively more responsive to the target group. These agreements may be general expressions of affiliation or of joint purpose, or they may be documented work plans and detailed processes for providing services and exchanging client information. These agreements should be accompanied by provisions for implementation throughout the system and for any requisite technical assistance (Stroul & Friedman, 1986). An interagency memorandum of agreement developed between education and mental health for the Bluegrass IMPACT project is contained in Appendix C on page 109. This agreement was developed by a committee representing educational agencies in the project region and negotiated between the Kentucky DMHMRS and the 22 public school districts in this region, as well as the Kentucky School for the Deaf. Included in the document are five principles of agreement relating to confidentiality, costs of services, transportation, due process procedures, and management information systems; descriptions of specific referral, assessment, treatment planning, intervention, and follow-through procedures, and a statement regarding the effective date of the procedures. Attention to detail is important in such interagency agreements because of the complexity of the information and services shared (as well as the sensitivity of the former), and the lack of experience most agencies have in working together. A consent to treatment and consent for release of confidential information also was developed to facilitate interagency collaboration and information exchange. A copy of this form is also included in Appendix C.

Strategies for Technical Assistance and Training

These strategies are directed at both the state and local levels, and are designed to provide information on concepts and goals, policies and procedures, tactics for identifying and solving problems, and evaluation techniques. Surveys and other assessments are among the methods used to plan technical assistance and training initiatives (Stroul & Friedman, 1986).

Training strategies often involve sponsoring, cosponsoring, organizing, or contracting for statewide or regional conferences, workshops, and seminars. Ongoing training programs, such as a statewide training program for case managers, may be designated and conducted (Stroul & Friedman, 1986). Training materials and resources have been developed by CASSP, and states that have initiated plans for SED children and youth may be willing to provide technical assistance. Robert Cole, Deputy Director of the Robert Wood Johnson Foundation Child Mental Health Initiative, observes that training has played a key role in the success of projects supported by the Foundation (R. Cole, personal communication, May, 1991). Training for parents, advocates, legislators, and the public, as well as for staff, is the vehicle through which an interagency attitude is communicated and learned.

Strategies for Constituency Building and Participation

Three points are important with regard to this set of strategies. First, key individuals and groups should be included in planning for the target population at state and local levels. These key individuals and groups include parents, consumers, professionals, and child advocates as well as private sector providers and organizations, including businesses and health insurance providers. Second, strategies are needed to stimulate the development of new advocacy groups. Finally, state planners and policymakers are likely to favor strategies that generate public awareness and support for system development activities on behalf of children and youth (Stroul & Friedman, 1986).

To promote the development of new support groups and to facilitate advocacy activities, states can provide either material or nonmaterial support. Material support has consisted of sponsoring statewide and regional advocacy conferences and workshops, and providing funds for a variety of advocacy projects. Nonmaterial support consists of supplying information, such as legislative and budget information. Public awareness and support may be sought through media exposure, workshops, and presentations to government, civic, volunteer, and professional groups (Stroul & Friedman, 1986).

Strategies for Local System Development

The most widely used strategy in this category centers around the use of model or demonstration programs. Model programs provide working examples of community-based service approaches and, if effective, are very likely to persuade legislators and other decision makers of their viability. Such models also serve as a learning base for future plans, policies, and programs. Another widespread use of model programs is as a training and technical assistance resource (Stroul & Friedman, 1986). A variety of model programs have been developed to meet the diverse range of state and community needs. Three programs are highlighted in Chapter 7. As we mentioned previously, Bluegrass IMPACT serves as a model for Kentucky's state plan (Kentucky IMPACT). Although only in its first year of operation, Bluegrass IMPACT has provided training and technical assistance to interagency personnel throughout the state.

Interagency Program Planning and Development

As the foregoing discussion indicates, in order to establish a viable program, development must occur at both the state and local levels. Moreover, activities at all levels must be well coordinated to ensure that services are complete, available, appropriate, and accountable.

Leadership at the state level obviously has significant influence on the planning and delivery of services at the community level. However, states must offer practical assistance as well. Friedman (1985) has suggested several ways in which states can facilitate interagency services, including: (a) establishing policies to facilitate programs and the development of services; (b) providing resources; (c) providing technical assistance; (d) providing consultation; (e) establishing standards for communities to follow; and (f) developing monitoring and evaluation procedures to ensure that communities are providing adequate services. Again, establishing a mandate without offering tangible services to community-based providers is not adequate leadership. Even programs that are not part of a statewide implementation plan will need support and guidance from state agencies and legislators.

Although state planning and support is a necessary condition for successful implementation at the community level, it is not sufficient. As Stroul and Friedman's (1986) planning strategies indicate, much activity must occur at the local community level. Knoff (1990) offers 10 useful guidelines for enhancing community involvement:

1. Respond to what people want for their children by understanding the conditions of family and community life.
2. Adopt an ecological perspective; that is, see the child in the context of the family, and the family in the context of its social network and community environment.
3. Identify and capitalize on the strengths of children, families, and the community.
4. Promote a sense of community by fostering mutual aid, affiliation, and involvement in community life.
5. Promote empowerment by creating community processes that foster competence, control, and involvement.
6. Provide flexibility and diversity in programming as needed to adapt to community environments.
7. Coordinate with other groups and services to enhance the quality and continuity of programming.
8. Facilitate clients' access to other services.
9. Identify how institutions can adapt to provide optimal support to children and families.
10. Provide ongoing evaluation to identify and document the intended and unintended impact on the child, family, social network, and community environment.

These guidelines provide a philosophical as well as an operational basis for community-based interagency programs. Romeo, Mauch, and Morrison (1990) offer several observations that relate to a philosophy of community services for persons with psychiatric disabilities. Although their following observations target services for adults, they are equally relevant for programs serving children and families:

1. The consumers of mental health services can identify realistic goals for themselves, and these should be factored into planning a system's services.
2. The mission of the system is to help persons function better with the *least* amount of ongoing assistance from agents of the mental health system.
3. Improving client functioning, not simply maintaining them in the community, should be part of the system's mission.
4. Emotionally disabled persons' skills and supports relate to community outcomes more strongly than do their symptoms.
5. Clients need different services at different times, and at different levels of intensity.
6. Many persons with emotional disorders don't want the services that systems provide because they often find these unappealing, inappropriate, or demanding.
7. Many persons who work in programs serving clients have not been appropriately trained, nor do they possess natural clinical abilities.
8. New technology and new facts relevant to community support and rehabilitation are being reported almost daily, and these new developments must be incorporated into the plan in an ongoing manner.

On a more specific level, planners must address the issue of how to implement the planning process. The Regional Resource Center Task Force on Interagency Collaboration (1979) developed a process outline for interagency planning, shown here as Figure 5-2. This flowchart depicts specific steps for five stages of planning: establishing the need, establishing the database, identifying the planning targets, establishing interagency provisions, and assuring collaboration in service delivery. The strategies described by Stroul and Friedman (1986) can be applied within this framework. It is important to note that coordinated interagency case planning and implementation are much less likely to occur if decisions previously have been made at higher levels, planning has occurred unilaterally by a single agency, or participation has been restricted to state agency leaders. To successfully establish an interagency attitude among all constituents in the system of care, system planners must model this attitude through broad-based multiagency participation.

Leone (personal communication, August, 1991) suggests that one strategy for promoting interagency participation, local system development, and constituency building is through the introduction of "self-in-

FIGURE 5-2
A Process Outline for Interagency Planning

Establishing the Need	*Determine* needs and rationale for initiation of interprogram collaboration project. 1.0	*Define* service delivery population of interest. 2.0
Establishing the Database	*Identify* agencies and programs serving or authorized to serve the target population(s) and contact agency administrator. 3.0	*Define* current program policies and services and responsibilities of identified programs. 4.0
Identifying the Planning Targets	*Compare* local programs and procedures across agencies to identify gaps, overlaps, constraints, and other linkages. 5.0	*Identify* local policy and procedures wherein modifications would enable satisfaction of need and rationale for collaboration and *specify* the needed modifications. 6.0
Establishing Interagency Provisions	*Determine* which modifications can be made on the local level and incorporate these modifications in a local interprogram agreement. 7.0	
Assuring Collaboration in Service Delivery	*Enable* implementation of interprogram modifications. 8.0	*Implement* local evaluation functions. 9.0

Source: From Guidelines for Preparing Interagency Agreements. *Interagency Collaboration on Full Services for Handicapped Children and Youth, Volume Two: A Guide to Local Implementation*, 1979, by the Regional Resource Center Task Force on Interagency Collaboration, Department of Health, Education, and Welfare. Reprinted by permission.

terest arguments." Self-interest arguments suggest that specific outcomes (e.g., the formation of interagency services for EBD children and their families) be linked to the professional status, interests, or well-being of those in a position to change the manner in which services are delivered. Such tactics create an institutional support base for interagency collaboration, in that successful integration of information and intervention services becomes one criterion for evaluating agency effectiveness.

The crux of planning is developing policies and procedures for dealing with specific cases at the community level. Strategies for individual case management are available in the literature (e.g., Morsink et al., 1991). The model implementation projects described in Chapter 7 illustrate some of these strategies. Here we will provide general guidelines for case management. The Multi-agency Network for Severely Emotionally Disturbed Children (1987) developed a number of useful suggestions at this level, including ground rules for multiagency case planning, a set of principles, and general guidelines. Their recommended ground rules include the rule that only one person at a time can serve as a client's designated case manager on the case management team. The role may shift across time, but case manager transfers must be formally designated in the case plan. This rule prevents confusion and bickering regarding who facilitates the meeting agenda for the client. The Network advises that all members of a case management team continue to serve as the representative of their agency's portion of the case plan. This policy avoids confusion about who is empowered to speak for the agencies represented on the team, and increases the likelihood that services promised will be delivered. The Network also suggests that if community-based alternatives to residential treatment are not yet achievable, the case management team should strive to plan a community-based residential placement for the shortest possible time. This is not to say that residential placement, even psychiatric hospitalization, is not needed for some cases, but when provided, specific timelines should be set to to return the client to the community and home. Furthermore, it is recommended that the case management team be responsible for a client's interagency case plan even when placement in residential treatment is necessary. Finally, the Multi-agency Network for Severely Emotionally Disturbed Children recommends that a plan that includes residential placement should always include a discharge plan constructed by the case management team upon the client's admission to the residential program. A representative of the residential treatment program should be a member of the team and is responsible for delivery of the residential services specified in the case plan. Other members of the team should strive to support the family and assist in the client's transition back into the community.

The principles that the Multi-agency Network for Severely Emotionally Disturbed Children (1987) present are directed at both the content and process of case planning:

- Residential treatment should not be viewed as the treatment of choice for most children and youth.
- Youngsters with EBD will often show significant improvement and do so sooner if treated in their own communities and preferably in their own homes.
- The sooner an EBD child can be identified and the sooner a community multiagency case plan can be constructed and executed, the more likely the child will respond to treatment.
- Children who are at risk for residential placement deserve to have a formally designated case management team made up of the direct service persons from the various agencies who are or should be working directly with the child and family.
- All case management teams should be expected to learn to meld their individual agency case plans into a multiagency plan.

A general format suggested by the Multi-agency Network for Severely Emotionally Disturbed Children (1987) for conducting case planning meetings is presented in Table 5-3. A one-hour format used in conducting Kentucky IMPACT case conferences is contained in Appendix D on page 119. This appendix also contains a checklist developed by Phillips (1990) to facilitate these meetings.

Problems and Barriers

In the relatively brief history of coordinated interagency services, almost as many problems and barriers have been identified as there are persons to perceive them. However, most of these are reducible to a fairly common set. For clarity of discussion, we have organized these by the following levels: system, agency, individual profession or discipline, and case management and team functioning. Because many problems occur at more than one level, our grouping is arbitrary.

Problems at the System Level

Problems and barriers at the system level include the significant challenges of organizing and encouraging human service agencies to collaborate with each other. The bureaucratic superstructure that envelops human services in our culture has a long tradition that is difficult to overcome (Nelson, 1989). Children with behavior problems and their families are the legitimate clients of a multitude of service providers, most of whom are in separate locations, have different eligibility criteria, and are unaware of the services offered by other agencies. Furthermore, these

TABLE 5-3
How to Conduct Community Case Planning

- Establish case objectives by stating outcome conditions it will take to close the case.
- Draft a case plan which addresses the case objectives and prescribes those services for which each agency represented on the case management team is responsible for providing directly and for which a referral to an external agency or program must be made.
- Convert the draft case plan into a list of tasks associated with persons and agencies the team believes are or should be working with the child and family.
- Identify an appropriate case conference facilitator.
- After identifying the facilitator, the case management team may offer to help get the case conferees together, but the facilitator should be allowed to coordinate the logistics.
- Each agency should be asked to send a representative to the conference who either is already carrying the case or is in a position to accept a service-related assignment as a case plan task member.
- On the case conference day, the facilitator should be prepared to assertively preside. It is important that ground rules be established with regard to confidentiality and efficient presentation of the facts and problems of the case.
- Conferees should be asked to sign a declaration acknowledging the confidentiality of the conference and pledging not to discuss the case outside of the conference circle.
- All materials distributed at the conference must be strictly control led. Materials should not be taken away from the conference unless they are to be placed in an official agency file.
- The person originally requesting the community case conference should be prepared to make the initial presentation to the conferees. This overview should specify the presenting problem, the presenting agency's objectives, and an overview of current and previous interventions.
- Two minutes of follow-up questions and responses focusing on the clarification of facts come next in the conference process.
- The facilitator continues to preside over a series of additional agency presentations. In most cases, the facilitator will know ahead of time which agencies are involved actively in the case and will have a presentation to make. Usually, no more than 5 minutes per agency is allotted for each to explain case objectives and past services. As in the opening presentation, 2 minutes is allowed for follow-up questions and requests for clarification.
- After all presentations are made (usually requiring 35 minutes) it is time for the conference members to design an interagency service plan. It is helpful for the facilitator to stand in front and lead the group through specifications by recording specific suggestions on a blackboard or large easel and pad. Specify *what* (task assignments), *who* will be responsible, and *when* the activities or services are to be conducted.
- The facilitator then clarifies that those persons with task assignments on the plan constructed by the group are now officially members of the case management team.
- The facilitator then leads the group to designate a coordinating case manager for the execution of the interagency case plan. Often, the interagency case manager is the person with the most assignments in the plan or who has the most direct working relationship with the client.

Continued

TABLE 5-3 (continued)
How to Conduct Community Case Planning

- As needed, the case manager schedules the next follow-up meeting.
- At follow-up conferences, it is often necessary to modify the case plan assignments and schedules.
- The facilitator (who may or may not be the interagency case manager) is responsible for recording and disseminating copies of the current case plan to all members of the team.

Source: From *Building and Managing the Multi-agency Case Plan*, by the Multi-agency Network for Severely Emotionally Disturbed Children (June, 1987). Tallahassee, Florida. Reprinted by permission.

agencies are separated by different philosophical beliefs regarding the source of clients' problems—as well as by political turf issues, such as competition for public funds and clients, differences in goals, vocabulary, and technology. This means that the potential consumer of multiagency services must travel to each agency to apply for and to receive services, must meet different eligibility requirements and learn different vocabularies for each service, and must be exposed to different and often conflicting treatment philosophies and technologies (Edgar et al., 1987).

As might be expected, another set of problems concerns financing a system of care. The shared or pooled funding issue has been difficult for many communities to address (Jacobs, 1990). Problems may exist with regard to the flexibility and coordination of funding. An endemic problem is the underfunding of human services in our society. To some extent, this shortage can be compensated by strategies to create funds that are pooled from multiple agencies and used flexibly to support case management. Localities usually lack the pooling of funds that allows for such flexibility in treatment. As a consequence, children tend to receive the services that currently are available rather than the services appropriate to their needs. Also, without cross-agency sharing of funds, children and families may be restricted to those services or resources available through the agency that serves them. Case managers have severely limited options if they do not have sufficient funds to purchase individualized services or cannot access other agency funds for their clients. Thus, flexibility in funding is a critical factor in implementing a successful system of care. The funding coordination that can result through fiscal partnerships among agencies is difficult to develop. Agencies other than mental health that serve children (e.g., schools, child welfare, juvenile justice) may be competing in the state legislature for limited funding allotments. Therefore, they tend to view mental health as a competitor for resources, rather than as a partner (Jacobs, 1990).

Agencies also may be concerned that once external funds are withdrawn, the money used for flexible wraparound services will have to come from their share of state funds. Also, control of funds historically has been associated with control of decision making, a privilege agencies may be unwilling to relinquish (R. Cole, personal communication, May,1991). Separate case eligibility encourages parents and providers to place children in hospitals as a means of acquiring Medicaid reimbursements. In addition, private insurance payments constitute powerful incentives for residential providers to keep children in the "deep end" of the service continuum. Even more detrimental to serving children in communities is the pressure exerted on some parents to relinquish custody of their child in order to receive care, which often is residential (Jacobs, 1990).

Other system-level barriers have been cited by Johnson (1989). These include the lack of a centralized database for tracking clients, the absence of a common procedure for information dissemination, difficulty in defining decision-making rules among program developers, and procedures for confidentiality and the transfer of records. Elder and Magrab (1980) identify as problems the lack of an organizational structure to bring agencies together, a temptation for service delivery designers to become preoccupied and fixated on the system design rather than the functional roles of the system, and a lack of time to include staff in the planning effort. If interagency service delivery is attempted on a statewide level, all of these problems may be greatly exacerbated (M. Pennington, personal communication, May, 1991).

Problems at the Agency Level

Many of these problems extend to the agency level. The roles of particular agencies with regard to serving EBD clients and their families may be poorly understood, or agencies may disagree about the definition of the target population for interagency services. This problem may be particularly acute regarding differences between public and private agencies, These issues may be expressed in terms of variance in client eligibility (Johnson, 1989). Historical patterns involving a lack of communication among agencies are likely to give rise to such problems as "turfdom," competition over clients, jealousy concerning discrepancies in resources, skepticism about program feasibility, and failure to allocate responsibilities to the program (Magrab & Elder, 1980). Myths develop in the professional community about what various agencies and disciplines will and will not do, the quality of their personnel and their services, etc. Agencies with long histories in the state or community are especially prone to a sense of competition. Moreover, they may have developed parochial interests that cause them to be myopic regarding the needs of the broader community (Elder & Magrab, 1980).

Problems at the Professional Level

With regard to problems at the professional level, Wolfe (1988) observes that the very nature of a profession seems to require separateness—a clear and distinct identity based on unique expertise and an unambiguous role assigned and sanctioned by society. Thus, the process of becoming a professional shapes us to be like others in our profession and less like members of other professions. Although such distinctions certainly do serve some useful purposes, they also may create competitiveness, which often is not useful. Competition between professionals probably is most unhelpful to the person seeking professional help, because in becoming a client of one profession, the person is isolated from contact with other professions. Wolfe suggests several reasons for the emergence of unhealthy professional competition, including ignorance of other professionals' roles and contributions to the client, professional egocentricism and prejudice, fear of losing autonomy and power, as well as such human frailties as pride and stubbornness.

Problems at the Case Management Level

These difficulties and barriers affecting interactions among professionals also impact activities at the case management level. In addition, key personnel may be lacking or their availability severely limited, particularly in sparsely populated areas, (Johnson, 1989). A major problem at the agency level is the amount of time required for interagency activities, including meetings and paperwork. Such activities entail agency financial expenditures, and they are not likely to be as valued by staff as direct client contact activities, which are seen as the chief mission of the agency. In addition, agency staff who lack information or who work in areas where services are limited may make inappropriate referrals.

A host of case management problems involve dysfunctional interactions among members of treatment teams. Bailey (1984) suggests three sources of dysfunction: in the developmental process, among team members, and in the whole team structure. Developmental problems include lack of time for team building, lack of leadership, or staff turnover. Interpersonal problems among team members may result from conflict between two members or may be confined to a single person who is overly dominant, not treated as an equal, or has conflicts with all other members on the team. Problems in team structure result in an underperforming team because task completion and team functioning are affected: by a weak leader or members who are unwilling to assert themselves; by an overstructured team that is rigidly defined with few options for flexibility; by a team with ambiguous roles in which the lack of clarity leads to conflicts, confusion, or withdrawal; or by a disorganized team characterized by a lack of leadership, lack of direction, and a lack of structure.

Problem Solving

As our experience in attempting interagency planning and program development increases, so too will our ability to identify and resolve problems. Fortunately, a climate favoring community-based programs for children and families has emerged during the last decade and appears to be gaining strength. The populations targeted for interagency programs include preschool children; families living in poverty; children and families affected by drug and alcohol abuse, physical abuse, or family violence; children and youth at risk for delinquency, as well as many others. Information and skills gained from the implementation of interagency programs for any given population are applicable to other populations as well. For example, Knoff (1990) reviewed programs aimed at the primary prevention of emotional and behavioral problems in preschool children. He identified the following elements of successful community involvement in such programs:

- A bottom-up approach to program planning and implementation, which includes community participants in the identification of needs and goals, is desirable.
- The community context, including culture and values, is an important aspect of planning and implementation.
- Programs are flexible and responsive to community needs.
- Leadership training and support are essential for meaningful and effective community involvement.
- Coordination of services increases comprehensiveness, continuity, and effectiveness of programs.
- Building on community strengths and resources facilitates the development of healthy communities.
- Changes made in community or institutional environments can effect long-term gains in clients.
- The enhancement of social networks and the resulting reduction in isolation can have positive and measurable effects on individuals at risk.
- Primary prevention programs and research are translated into the language spoken in the communities where programs are located.

These elements suggest the features that characterize successful programs. But how do interagency programs acquire these traits while avoiding the pitfalls of past history and poor planning? Again, the growing literature addressing interagency service delivery problems is a valuable resource. Space limitations do not permit us to provide a detailed description of trouble-shooting and problem-solving suggestions. Moreover, while strategies are general, they must be tailored to the unique circumstances of each program; thus, a laundry list of suggestions probably would be of little help. The resources listed in Appendix B on page 93 may be consulted to address particular areas of difficulty. Also, planners may find similarities between local issues and those addressed by the model programs described in Chapter 7. Here, we attempt only to identify some general strategies and suggestions.

Kirst (1990) proposed two sets of strategies to address the system of children's services. **Short-run improvement strategies** target changes that can be implemented without major overhauls in public policy. One such strategy is to locate as many services as practical in one place, thereby increasing the convenience of accessing interagency services. Kirst observes that school is the institution that has the most sustained contact with children and families, but the school should not be the only hub. Child care centers, churches, and other communal sites also should be considered. Moreover, parents may perceive schools to be a hostile place and may feel more comfortable in other settings. Prior to deciding upon a location for multiple services, Kirst advises that planners agree on a coequal strategy to ensure that no single agency is "in charge" of a group of subordinate agencies. If one agency, such as the public schools, is in charge, the other agencies probably will do little more than they did previously. If colocation is arranged, schools should not have to divert their scarce resources to management and staffing. Instead, county and other local agencies should pay for their own personnel and provide an overall coordinator (Kirst, 1990).

Another short-run strategy is to base collaboration on a community-wide planning process that originates locally and includes broad citizen involvement. Techniques for collaboration should be discussed by line workers (teachers, social workers, parent educators, etc.) from the start (Kirst, 1990). These tactics can be reinforced by a set of escalating steps that Kirst refers to as "hooks," "glue," and "joint ventures." "Hooks" formally link a client's participation in one program with participation in another, as when foster children automatically qualify for local job training. "Glue money" allows one agency to subcontract with others and assures clients that they can get services in one place. The lead agency serves as the "broker" for the client and subcontracts with other service providers. The glue money could be used to pay for a case manager, who procures and coordinates resources from other agencies. "Joint ventures" enable several agencies to create partnerships in raising funds for jointly operated programs. This also reduces the tendency for agencies to divert sources of funding away from the goals and targets of the program. Kirst emphasizes that the credibility of initial community planning is a critical element in these financial arrangements. Parental participation in program design also is important. Leaders at the federal, state, and local levels must provide seed money for this planning because service integration takes time and resources. Kirst recommends that these short-run measures be accompanied by an evaluation plan in which clients' functioning at periodic intervals is compared with baseline measures.

Short-run strategies must be supplemented by **long-run strategies** that focus on the roots of service fragmentation. University training programs are an important target for changes that have long-term impact on professional collaboration. Kirst (1990) suggests that more interprofessional preparation programs, such as one program operating at Ohio State University, be created. Programs should be developed at both the preservice and inservice level, and should target interprofessional policy analysis as well as the opportunity for students and professionals from various disciplines to work together informally.

Another long-range solution involves a major rethinking of local government structure in this country. Kirst (1990) identifies the Minnesota Youth Coordinating Board as a model structure. Power is shared between the city, the local school district, the county, the park and recreation board, and the library board. The board has the authority to levy a local property tax to promote integrated and quality services for children. A written interagency agreement identifying which agency is responsible for what services is an important follow up to a revised policymaking system. Policies involving confidentiality and sharing of client information must be revised to foster collaboration instead of preventing the use of information by other agencies. Kirst recommends that information systems among agencies be merged and computerized.

The transfer of up-to-date client information has proven to be an obstacle to collaborative interagency case intervention. Such data as demographic information, assessment reports, treatment plans, and case contact reports must be accessible to agencies participating in case management. Because changes in client and environmental variables may occur rapidly, it is important that client databases be accurate and up-to-date. In a number of states, agencies are developing strategies to expedite the monitoring, exchange, and revision of client records. For example, Florida's Department of Education has developed the Florida Automated System for Transferring Educational Records (F.A.S.T.E.R.). This system was created to facilitate interdistrict student records requests through a centralized computer system. It also is used in the exchange of information between schools and postsecondary institutions (K. Brock, personal communication, May, 1990). Although in the developmental stages computer information systems are costly and labor intensive, these initial outlays reap later dividends in terms of saving staff time and providing prompt, accurate client information. As human service agencies enter the computer age, access to the necessary hardware and software will become simpler. Such issues as compatibility among systems and protecting the confidentiality of client information must be addressed before a centralized client information system is developed.

State government should have an active role in funding local planning and providing start-up capital. But Kirst (1990) identifies as a prerequisite the merger of state legislative jurisdictions and a new state mechanism for waiving state regulations created for various human service agencies. California has passed legislation creating a State Interagency Children's Services Coordinating Board, composed of state agency leaders. Counties are encouraged to create their own interagency councils to include the following duties:

- Ensure collaboration and county-wide planning for the provision of children's services
- Identify agencies that have significant joint responsibility for children and family services
- Identify gaps in services to specific populations
- Develop policies and set priorities to ensure the effectiveness of services
- Implement public and private collaborative programs
- Provide for county-wide interagency case management to coordinate resources.

These interagency councils will devise 3-year plans for phasing in a coordinated children's delivery system (Kirst, 1990). The Kentucky legislation, described in a previous chapter, addressed the same goals, but countywide interagency councils are substituted by councils serving a multicounty area. As Friedman (1985) observes, some counties are too small to need or to afford a full system of services. In such cases they can work in partnership with other counties. Also, some low incidence disorders (e.g., hearing impaired emotionally disturbed children) may need to be served by a program serving a number of communities.

Finally, Kirst (1990) points out that both short- and long-run strategies will not be successful if parents are not involved and helped. Parent education and programs that result in improved family processes are crucial because public services are not sufficient by themselves. The participation of parent and advocacy groups in the initial planning and development of services will increase grass-roots support and communication throughout the system while reducing the potential of client alienation.

Inevitably, a change in educational or residential placement must be considered for some children and youth. As Behar (1990) observes with respect to North Carolina's statewide continuum of care program, while only a fraction of the children in the state program are hospitalized, this number is not zero. For a variety of reasons, changes in placements may be necessary: from a natural to a foster home; from one school to another; from regular to special education; or from school and home to hospital, residential school, or correctional facility. And, of course, transitions must occur both ways, especially in programs aimed at returning children to community settings from more restrictive environments. The management of such transitions is the litmus test of effective interagency collaboration. Edgar and his colleagues (Edgar et al., 1987) have studied transition problems for some time, and have developed strategies to facilitate transitions between a number of human service agencies—from infant centers and Head Start programs to public schools; from secondary special education programs to community-based programs for persons with developmental disabilities; from secondary special education to vocational rehabilitation programs; and for the delivery of concurrent services to disabled children and youth served by more than one agency.

One such model involves the transition of juveniles between schools and correctional programs (Webb, Maddox, & Edgar, 1985). This model was developed from the authors' study of how public schools and the juvenile justice system relate to one another and process information. They identified problems in four broad areas: awareness of other agencies (including their policies, procedures, client eligibility criteria, and programs); the transfer of records from schools to institutions and vice versa; preplacement planning; and maintaining placement and communication. Webb et al. (1985) developed assessment procedures and 36 strategies addressing specific problems in these four areas. For example, strategies targeting interagency awareness problems include:

1. Holding a meeting of interagency administrators. A major product of this meeting is a list of roles and responsibilities of schools, community workers, and institutions that is disseminated among the involved agencies.

2. Providing staff inservice training, including sessions for selected staff from each of the involved agencies. These training sessions provide information about each agency.

3. Scheduling institutional visits, in which staff from schools visit institutions and institutional staff visit schools.

Each strategy contains specific guidelines and materials (e.g., meeting agenda, outlines of activities, forms for giving and receiving information, and evaluation forms). This model can be adapted to other transition problem areas.

The successful implementation of community-based interagency programs involves processes that must occur in several stages and at multiple levels. It is critical that planning involves persons representing all concerned parties from state agency personnel to consumers. Furthermore, from the very first, agency planners must model an interagency attitude (Phillips, 1991). Input from the professional and lay community must be sought constantly and actively and used in a systematic formative evaluation process. Finally, it is important to use existing resources to save time and to avoid repeating mistakes.

6. Outcomes and Benefits

The goals envisioned by the creators of community-based interagency projects are clear and consistent: to enable children to maintain a good quality of life and mental health in their home communities; to more efficiently and effectively use community resources; and to reduce the use of expensive and unnecessary deep end services. These goals translate into straightforward evaluation plans; however, because the implementation of interagency programs is still in its infancy, comprehensive outcome data are not widely available. Given the lack of systematic evaluation procedures and of consistent research findings, reported outcomes should be considered to reflect "best practices" rather than data proven techniques (E. Edgar, personal communication, July, 1991). In this chapter we present the outcomes and benefits desired of interagency programs, review strategies that have been used to achieve these results, present some available outcome data, and highlight some of the components of a comprehensive evaluation plan.

Desired Outcomes

The outcome sought by virtually all interagency programs is to reduce the number of children receiving services at the "deep end" of the service continuum (residential treatment and psychiatric hospitalization). The belief that early community-based intervention will cost less than the enormous financial burden of late intervention involving out-of-community placement is widespread (Multi-agency Network for Severely Emotionally Disturbed Children, 1989). However, because of the number of children and families who are potential consumers of community-based services, reducing the cost of these services may not be a realistic goal. As Edgar (1990) suggests, many additional billions of dollars will be needed to support social programs that address the root cause of the majority of EBD children and families' problems: economic poverty. A shift in financial contingencies is needed to ensure adequate support to test the efficacy of community-based programs.

Jacobs (1990) has summarized a variety of strategies used by states to change financial incentives and to provide more resources for community-based services. For example, the Alaska Youth Initiative (AYI) uses money that would have been spent on out-of-state residential placements to provide individualized treatment programs for children. Vermont received a waiver from the Health Care Financing Administration to test a program in which children and youth who meet admission criteria for inpatient hospitalization can receive out-of-hospital services paid by Medicaid. In 1984, Ohio passed legislation creating an Interdepartmental Cluster for Services to Youth and requiring each county to establish a local cluster for services to youth.

The Robert Wood Johnson Foundation (1988) Child Mental Health Initiative's primary focus is to create major changes in the financing, organization, and delivery of services for EBD children and youth. The Foundation has summarized many of the fiscal options a state or locality should consider in designing strategies to overcome fiscal problems. The highlights include:

- Expanding private insurance coverage for services through negotiations with insurers or through enactment of statutes.
- Expanding Medicaid coverage by taking advantage of existing optional services categories.
- Restructuring administrative fiscal relationships between state and local government agencies to provide greater flexibility and incentives for expanding the range of services.
- Reducing state hospital capacity in order to make available resources for community-based services.
- Reallocating state monies by capping foster care and group care budgets, reprogramming block grant monies, or guaranteeing the provision of home-based services for clients of the child welfare system.
- Blending mental health, education, juvenile justice, and child welfare resources to increase the availability of services for which there are joint agency responsibilities.
- Developing third-party billing plans to ensure that school systems recover some of the costs of supplying health and supportive services to children with EBD.
- Obtaining new state funds for a broader array of home- and community-based mental health supportive services. (Robert Wood Johnson Foundation, 1988, pp. 4–5).

Data regarding the effectiveness of these cost-efficacy strategies are just beginning to appear in the literature. Senator Edward Kennedy (1990) reports that states with well-developed adult community programs (e.g., Colorado and Wisconsin) have been able to reduce the number of days of hospital care per capita to as much as 50% below the national average. Perhaps even more importantly, Kennedy indicates that persons in community programs have fewer symptoms, greater life satisfaction, more positive social relationships, and spend less time unemployed than do comparable persons who remain in the hospital. Behar (1990) notes that the annual cost of serving about 1,200 children in community-based programs in North Carolina is $30 million dollars, or $25,000 on each child, "a modest amount compared to the cost of hospitalization or other types of residential care" (p. 133). In 1986, the Florida Human Resource Services Case Review Committee and the SED Network Planning Team began a collaborative effort to develop and implement community-based discharge plans for eight youth who were living in residential treatment facilities. The projected annual costs of continued hospitalization for these clients was $218,057 through June 30, 1987. As a result of careful multiagency case planning, these children were able to return home and receive wraparound services in their communities at a total purchase of services savings of $107,303, or $13,413 per child (SED Network Conference, 1987).

Potential fiscal savings is only part of the desired set of outcomes. Reductions in the costs of deep end placements are achieved by retaining clients in community settings. On this point, it seems clear that programs are able to reduce the reliance on residential and hospital placements. Behar (1990) reports that only 18% of the children served by the AYI have required subsequent hospitalization or residential treatment; the rest are making satisfactory progress in their home communities. As we reported earlier, only a small fraction of the 1,200 children served in the North Carolina program are hospitalized (Behar, 1990).

Behar (1990) has proposed an evaluation model that compares services and costs of traditional programming for individual children with those of a system of care. Her analysis for a child with serious mental health problems is presented in Table 6-1, and an analysis for a child with moderate problems is shown in Table 6-2. This model shows the services provided and the specific costs of each. A services-by-cost evaluation model such as this clearly documents the resources and funds used to support children in community settings. Furthermore, it allows interagency planners to perform specific analyses of the services and costs on a client-by-client basis.

Such comparisons do not permit specific analyses of the effectiveness of services received, however. Data bearing on this issue generally are derived from individual client treatment plan goals and evaluations by caregivers and others regarding the adjustment and success of children. The evaluation plan proposed for Bluegrass IMPACT includes comparisons between accepted and nonaccepted children (who constitute a control group) at the time of nomination and at monthly, quarterly, and annual intervals on such items as number of problems, family and setting risk factors, a "restrictiveness factor" based on the total of placement ratings by the proportion of the year in that placement, as well as

TABLE 6-1
Comparison of Services for a Child with Serious Mental Health Problems

Current system: *Services*	*Days*	*Cost*
Hospital	60	$ 31,800
Residential treatment	365	113,150
Living at home outpatient for child and family	183	3,522
Total	608	148,502
Average cost per day: $244		
Proposed system: *Services*	*Days*	*Cost*
Hospital	15	$6,429
Group home day treatment outpatient for family case management	227	76,327
Living at home day treatment outpatient for child and family case management	183	18,296
Living at home outpatient for child and family case management	183	4,164
Total	608	105,216
Support services		3,000
		108,216
Average cost per day: $178		

Source: "Financing Mental Health Services for Children and Adolescents" by L. Behar (p. 137). *Bulletin of the Menninger Clinic*, Vol. 54, pp. 127–139. Copyright 1990, The Menninger Foundation, Topeka, KS. Reprinted by permission.

follow-up on the services and placements of nonaccepted children who were nominated (Illback, 1991).

Such data are useful for individual client tracking. However, they are not sensitive to the impact of systems changes on the services available to children and families in general, and on the growth of community-based services in particular. Friedman (1985) proposes that community-based intervention offers a number of benefits, including:

- Greater family involvement, which is frequently critical to the success of treatment
- Less disruption for the child and family, requiring fewer transitions in and out of the community
- Facilitation of involvement of other key individuals (e.g., extended family, teachers, ministers, coaches, etc.)
- Use of community resources, thereby reducing the cost of treatment

TABLE 6-2
Comparison of Services for a Child with Moderate Mental Health Problems

Current system: *Services*	*Days*	*Cost*
Hospital	60	$31,800
Residential treatment	183	56,730
Living at home outpatient for child and family	183	3,522
Total	426	92,082
Average cost per day: $216		

Proposed system: *Services*	*Days*	*Cost*
In-home crisis stabilization	30	$4,950
Living at home day treatment outpatient for child and family case management	213	23,640
Outpatient for child and family case management	183	4,776
Total	426	33,366
Support services	—	2,000
		35,366
Average cost per day: $83		

Source: "Financing Mental Health Services for Children and Adolescents" by L. Behar (p. 138). *Bulletin of the Menninger Clinic*, Vol. 54., pp. 127–139. Copyright 1990, The Menninger Foundation, Topeka, KS. Reprinted by permission.

- Increased likelihood of good collaboration between agencies on a local community level when the child remains in the community
- Greater community involvement, resulting in more support and advocacy for improved services
- The generation of local funding to match other sources
- Increased involvement of citizens as volunteers
- The creation of closer relationships between public and private sectors
- Greater accountability and less likelihood of abuse, since referral sources, family, and others can visit the child and the program on a more regular basis
- Increased likelihood that services that meet the needs of individual communities and that capitalize on community strengths and resources will be developed
- The increased likelihood of careful community planning
- The development of community acceptance of responsibility for serving its own children.

These benefits should be considered when developing an evaluation plan, so that the focus of evaluation will not overlook important variables regarding community mobilization.

Designing an Evaluation Plan

Each evaluation plan should, of course, be tailored to the specific circumstances of each state or community project. However, planners who follow some general guidelines will find the results more useful in terms of documenting program impact and demonstrating the need for more resources. First, a research component should be an integral part of a program evaluation plan. Not only are outcome data critical to establishing a valid database which guides future researchers, but also, research activities are a means to attract additional assistance from university professors, graduate students, and others, and to promulgate long-term outcome or short-term procedural studies that may influence future funding outcomes (S. Forness, personal communication, July, 1991).

Second, evaluation procedures should address both outcome and process dimensions. **Outcome data** include measures of child and family status before, during, and after intervention, as well as the types, duration, and costs of services provided. Ideally, comparable data should be obtained on control groups, some of which receive no treatment and some of which receive unintegrated treatment, to permit analyses of the relative efficacy of the program. Measures of social validity (Wolf, 1978) also should be taken regarding parent or caregiver and client (if appropriate) satisfaction with the results achieved. **Process data** include measures of the treatments given, the resources consumed, and service provider time expended. A major problem in the delivery of complex treatment packages, such as an interagency treatment plan, is provider fidelity to the treatment procedures as specified. Failure to implement a treatment plan correctly is a primary reason for the failure of interventions (Lane & Burchard, 1983). Therefore, evaluations of procedural reliability (Wolery, Bailey, & Sugai, 1988) should be conducted whenever feasible.

Evaluation also should occur on two levels. **Summative evaluation** occurs after intervention has been completed, whereas **formative evaluation** takes place during the intervention process (Howell, Kaplan, & O'Connell, 1979). The intervention process for children and youth with serious emotional and behavioral difficulties is likely to require extended periods of time; therefore, summative evaluation data, while useful in terms of overall program evaluation, may be less helpful to interventionists for planning and modifying services to individual clients. Formative evaluation procedures should include feedback loops from clients to providers and evaluators, as well as from providers to planners and evaluators—if such procedures are to result in meaningful adjustments in clients' programs. The data collected for formative analysis should consist of client progress, measured against short- and long-term treatment goals, as well as measures of client/caregiver and service provider satisfaction with treatment progress and the specific intervention procedures. It also is important to include procedures for other professionals and lay persons who have contact with the client to provide formative evaluation input. These persons often have perspectives on clients that are useful in evaluating and adjusting interventions.

Finally, because of the nature of human problems and the complex and difficult circumstances interagency programs for EBD children and their families must address, evaluation should entail long-term evaluation of outcomes. The ultimate measure of the effectiveness of interventions aimed at such chronic human conditions as social maladjustment and mental illness is success in adapting to life as an independent or semi-independent person. Furthermore, it is likely that a number of children with EBD will require long-term supportive environments (Wolf, Braukmann, & Ramp, 1987). The success of interventions for some individuals must be evaluated against the human and economic costs of prolonged institutionalization.

7. Model Programs

Although the preceding chapters have offered detailed information regarding interagency collaboration, the sheer volume and complexity of this information perhaps have left readers with an abstract impression of the actual process. Therefore, in Chapter 7 we present an overview of three programs: one statewide (the Alaska Youth Initiative), one regional (Bluegrass IMPACT), and one countywide (Ventura County, California). These programs are diverse in scope and demography and thus sample a reasonable range of characteristics likely to confront interagency planners. We will present only the highlights of each program in this chapter. More complete descriptions are provided in Appendices E, F, and G.

The Alaska Youth Initiative

The major impetus for the Alaska Youth Initiative (AYI) was the large number of children and youth with SED who were being sent out of state due to the shortage of residential treatment facilities in Alaska. Although the development of in-state residential facilities in the late 1970s resulted in a reduction in the number of out-of-state placements from as many as 200 at one time to between 40 and 90, the cost of supporting these youth was great. A survey of 37 states revealed that a total of 4,098 youth were in out-of-state placements, at a cost of $204,000,000 a year, or over $50,000 per child. The average cost to Alaska for each youth placed out-of-state was $71,000 per year. Other problems with such placements included difficulty in monitoring the programs and progress of the affected individuals, a lack of generalization and maintenance of treatment gains, and a reliance on excessively restrictive placements for youth. Youngsters sent out-of-state included juvenile offenders and children labeled as schizophrenic and behaviorally disordered. One factor that supported this practice was the benefits realized by individual school districts, who were no longer responsible for the costs of children's educational programs after they moved out of the local school district.

Most of the operating budget for AYI is derived from general state funds, which previously were used to pay for out-of-state placements. The AYI planners decided that the funds then being used to pay for the care of 37 youth out-of-state would be used to develop in-state services for these same youth. It also was agreed that funds would "follow the child"; they would be used flexibly for whatever was needed to serve the youth, except for paying the parents to care for their own child. An additional $600,000 resulted from a legislative initiative for youth who were at risk for out-of-state placement, and these children were added to the service population. A CASSP grant provided funds to hire specialists to coordinate youth services. The Department of Mental Health and Developmental Disabilities initially paid the administrative costs of the AYI. As the number of youth in AYI grew, regional staff were hired with funds that "followed" these children back into the state.

The first step in creating the AYI was to form an interdepartmental team (IDT), comprised of state-level staff from the Department for Youth Services, the Department of Education, and the Department of Mental Health and Developmental Disabilities. The IDT concept was patterned after the "Kaleidoscope" model used in Illinois. The agencies directly involved in the AYI include the Alaska Division of Mental Health and Developmental Disabilities, the Division of Family and Youth Services, and the Department of Education. Interagency agreements were developed among these agencies, and a collaborative arrangement was negotiated with the University of Alaska, which offers training for project staff.

The goal of AYI is to reduce the number of children and youth in treatment outside of Alaska. The AYI philosophy of "unconditional care" also was adopted from the Kaleidoscope program. This philosophy maintains that an agency or program should never give up on a child. If problems arise with regard to a placement or a program, it is the responsibility of the provider to change the structure of the service rather than to reject the youth from services. Thus, AYI services are derived expressly from client needs. This philosophy also incorporates the concept of normalization, which maintains that youth are entitled to live in a family or family-like environment instead of in large institutions or large group situations with children exhibiting similar disabilities.

Each AYI youth is provided with a formal treatment and education team, comprised of persons who are influential in the child's life. These persons may include an attorney, relatives, parents, social workers, therapists, teachers, and the youth, depending on his/her age and maturity. Thus, each child has a unique team. A team chairperson is appointed from this group. Because of the shortage of professional personnel in many parts of the state, extensive use is made of volunteers.

The team examines the youth's basic needs, including the following areas: residential, family, social/recreational, psychological, educational, vocational, medical, and legal. Based on these needs, the team develops a treatment and education plan, including a projected yearly cost. The plan is sent to the state capital for approval and if accepted, is implemented. Implementation includes specific responsibilities and timelines. An AYI staff person monitors the team members and the plan on an ongoing basis. In addition, monthly progress reports and evaluation data are sent to the state AYI coordinator. The AYI staff conducts quarterly reviews on each youth.

A standardized case evaluation format was developed from a list of "performance indicators"—behaviors or conditions (e.g., number of days in a mental hospital) that discriminate between youth who are emotionally "healthy" and those who are not. Through a process of social validation, this list was reduced to focus on a maximum of nine performance indicators for each client. This evaluation system provides outcome measures based on actual behaviors that the citizens of the state are most concerned with and want to see modified. As noted earlier, Behar (1990) reports that only 18% of the youth served by AYI have required subsequent hospitalization or residential treatment. Other outcomes reported include a reduction in costs, as in-state care has been found to be significantly less expensive than out-of-state care. Financial incentives to schools for retaining children in the system have been arranged, as well as disincentives for referring pupils out of state. An unexpected benefit is a reduction in staff turnover rates. Due to the success of the AYI, since its inception in 1985, the model has been extended to other populations, including children and adults with developmental disabilities, and adults with major mental illness.

Bluegrass IMPACT

As previously mentioned, Bluegrass IMPACT serves as a pilot project for the state SED plan, Kentucky IMPACT. The goals of Bluegrass IMPACT are to:

1. Improve interagency coordination of public and private services on behalf of children and youth with SED and their families
2. Ensure financing for a comprehensive system of care through creative interagency collaboration and public-private partnerships
3. Develop a full continuum of community- and family-based resources in the Bluegrass region as a successful demonstration of a system of care that could be replicated and
4. Reorganize services and provide new services that will make the system more flexible and responsive to the needs of children with SED.

Funding for Bluegrass IMPACT is provided from state monies made available through the state SED plan, flowthrough federal funds, and an implementation grant from the Robert Wood Johnson Foundation (see Chapter 3). The Robert Wood Johnson grant provided funds to employ professionals who otherwise were not available or who were in short supply in the area, including service coordinators, therapeutic foster care coordinators, a recreation specialist, in-school support specialists, in-home program staff, flexible response team members, and a data management specialist.

The project is directly supervised by a regional interagency council, which is responsible for the overall management and monitoring of the project. This council reports to the state interagency council, which oversees the statewide SED plan. The agencies involved in Bluegrass IMPACT include: mental health centers, district courts, social services, health departments, private child care facilities, 23 public school districts, and other community resources, who participated in signing interagency agreements to collaborate in delivering services (see Appendix C).

The target population includes children and youth who meet multiple criteria (see Chapter 2) and who fall in one of three priority groups: (a) children currently in the hospital or a residential setting; (b) children at risk of moving to a more restrictive setting; and (c) children who have a history of multiple out-of-home placements. A goal of serving 1,000 children and their families has been set for the 4-year duration of the project.

Service coordination (case management) is the core of the service delivery system. This is provided by the Local Admissions and Review Committee (LARC), composed of representatives from social services, mental health, schools, courts, and consumer groups. Three LARCs serve the 17 county region. These groups make admission decisions, review services, and facilitate local cooperation. Local Resource Coordinators (LRCs) in each of the three catchment areas staff the LARCs and provide leadership to the direct services staff. The service coordinators ensure that children receive appropriate services in a timely, coordinated manner. They broker and provide direct, tangible services, and offer a single point of accountability for all agencies working with a particular child.

Services

The resources made available through Bluegrass IMPACT permit a wide array of services. Flexible response teams provide wraparound services to children, including crisis stabilization, special in- and after-school support, specialized skill building (e.g., behavior management, social skill instruction), temporary shelter, in-home respite care, and transportation, as determined by each child's intervention plan. The flexible response team may provide additional support that will allow a family to maintain a child at home, or at least in the community, rather than place the child in a more restrictive residential setting. School support services are provided to increase the capability of regular teachers to maintain IMPACT children in their classrooms, to assist in the identification and support of children in counties where few children are identified, to increase the therapeutic potential of special education classes for EBD pupils, and to integrate children into peer group activities. School support staff also provide consultation and training for school personnel, intervention for the child and family in school and in the home, individual or group counseling, and assistance to parents in procuring additional services for children.

Intensive in-home services provide family-based support directed toward preventing or reducing the length of inpatient treatment or out-of-community placement of children. In-home therapists provide direct case management services, as well as skill building, behavior management consultation, support services, and problem-specific counseling to parents. Therapeutic foster care homes collaborate with the Department of Social Services and the community mental health system. Family service workers and IMPACT staff collaborate on service coordination, training assistance, in-home counseling, consultation, and crisis backup support. Additional support services may be provided by residential support specialists, who are employed by the Department of Social Services. While these professionals are independent of IMPACT, they work with children in residential settings to facilitate the transition of clients in residential treatment back into the community.

Many families require specialized services in order to respond to their children's mental health needs. Flexible funds are made available to purchase wraparound services. For example, wraparound funds have been used to pay children's fees for therapeutic camp programs. In addition, parent support and advocacy groups have been formed to explore broader systems problems that confront parents of IMPACT children, as well as other families and communities,. Finally, children receiving school support services can continue to be served during the summer vacation through wraparound purchase of care, volunteer programs, and IMPACT staff involvement.

For each child accepted for services, a Children's Interagency Planning and Implementation Team (CIPIT) is formed. The members of this team are those agency workers with primary responsibility for the child, including a service coordinator, a school representative, a mental health therapist, parents or guardians, and workers from any other agency involved with the family. The CIPIT develops and monitors an individualized interagency implementation plan. One member of the CIPIT serves as the case manager. All members have direct responsibilities for plan implementation.

Individual children's interagency intervention plans are monitered by a service coordinator, who keeps concerned parties informed of the child's progress, of deadlines for decisions and services, and of any problems that develop. Clinical assessment measures are obtained at the time of client intake, at 6-month intervals throughout implementation, and upon exit from the program. A computerized tracking system has been developed, which facilitates the monitoring of clients across agencies and provides regular information about goals, time frames, deviations from treatment plans, and so forth. The project evaluation plan also calls for tracking child/family demographic and risk factors, residential living arrangements for children accepted into the program, as well as children in a control group who receive the services normally available without IMPACT. However, some LRCs have initiated CIPITs for children not accepted into the project, thereby providing these youth with coordinated interagency services. Since Bluegrass IMPACT has been implemented only a few months, summative outcome data are not available at this time.

A major thrust of Bluegrass IMPACT has been the training of staff, parents, and other professionals. A training curriculum has been developed, and includes the history and philosophy of the project, operating procedures, an orientation to the major agencies involved, interagency collaboration and consultation, assessment procedures, the planning process, program evaluation procedures, strategies for working with parents and parent groups, and methods of supervision. Training workshops have been conducted at several sites. Bluegrass IMPACT has been designated to provide training for implementation of the statewide SED plan, and workshops have been held around the state. In addition, a policy and procedures manual has been developed.

The Ventura Model

The Ventura Model originated in 1984, when the California legislature passed Assembly Bill 3920, establishing a 2-year demonstration project in Ventura County to design and implement a comprehensive, coordinated system of mental health services for children. This bill was amended in subsequent years by legislation that increased county mental health responsibility, required a county plan for a coordinated system of care, emphasized case management, added client and cost outcome goals, and extended the model to other counties and populations. A countywide interagency network was created, overseen by an Interagency Juvenile Justice Council, a Youth Connection Board, an Interagency Case Management Council, and a Youth Connection Resource Development Project. These agencies established coalitions among service agencies and between public and private providers. A pool of funds was created from the blending of existing agency budgets, including probation, county schools, and mental health. These monies were supplemented by new state mental health funds.

The Ventura Model embraces a core value that a community-based, interagency system of mental health care that targets the most disturbed children will provide the highest benefit to children, their families, and the community at the lowest cost to the public. Fundamental goals are to enable SED children to remain with their families or foster families, to attend and progress in public school, and to avoid committing crimes. Specific objectives include: reduction of court-ordered residential placements; reduction of recidivism by juvenile offenders; reduction of hospitalization and residential placements; and increasing school performance and attendance. Originally, priority was given to children at risk for out-of-home placements. However, the target population was subsequently extended to include juvenile court wards, court dependents, mentally disordered children, SED children, and other children and youth receiving intensive public services.

Children are identified for services on the basis of a number of risk factors, including a history of out-of-home placement or eminent danger of such placement, the existence of family or individual pathology, and placement in special education EBD programs or on homebound instruction. An inventory of available youth services and a continuum of care serve as guides for mental health case management teams, who are responsible for conducting assessments, developing a service/treatment plan in collaboration with involved public and private agencies, linking community resources to residential agencies in order to facilitate transitions back into the home and community, and advocating for the client with a variety of public and private agencies. Case management involves coordinating educational and community services and providing limited direct services.

A unique feature of the Ventura Model is the Ventura County Youth Connection, a group of business leaders, professional practitioners, religious community leaders, a juvenile court judge, and members of the Board of Supervisors. This group is supported by staff from the county Department of Mental Health, the public social service agency, and Interface Family Services. The purposes of the Youth Connection are to create policy and develop plans to provide for the unmet needs of high-risk youth, to ensure that the Youth Connection's role is complementary to that of the public sector—to develop voluntary services and financial participation for needed services and to advocate for high-risk youth in private and public forums. The Youth Connection has been highly successful in creating a bank of goods and services that have aided hundreds of children.

A monitoring system is in place to track children over time and across agencies. Also closely monitored are public costs, recidivism of juvenile offenders, public school attendance and performance, client living arrangements, and interagency policies and procedures. Outcome data indicate that the Ventura Model has been successful in meeting its goals while at the same time avoiding the costs of more expensive services and placements.

These three projects illustrate different approaches to working with a similar client population. Each is designed to serve a different jurisdiction, and each has developed unique strategies to deal with the issues of funding, organization, and interagency collaboration. The AYI is a system of care designed to address the problems of a shortage of professional services and vast geographic distances between services. Bluegrass IMPACT attempts to bolster existing agency services with additional staff and interagency linkages in an area that is diverse in population and wealth. The Ventura Model emphasizes interagency collaboration and private sector involvement in an area that is relatively well endowed with human service agencies.

8. Conclusions and Recommendations

In this book we have attempted to synthesize and analyze the disparate and voluminous literature relating to interagency services to children and youth with EBD. It is our hope that we have provided useful information and access to resources for those who are in the process of initiating interagency planning, or who are contemplating such a task. This final chpater contains several observations and recommendations based on our study of this topic.

First, we think it is abundantly clear that interagency planning and service delivery is a complex process. Also, it is a new endeavor for most agencies and professionals. As Edgar et al. (1987) observe, the history of human service programs in this country is one of haphazard development:

> Out of the concern of lawmakers, community leaders, and special interest groups driven by a vocal constituency or by observed need, programs have been created to respond to needs for health, education, and social services. In most instances the programs were developed for a specific clientele (e.g., Crippled Children's Services), and almost all human service programs have a target population to whom they provide services. The bureaucratic approach to identifying that population is eligibility criteria, which restrict the clientele that may receive services. Most agencies have definite entrance and exit criteria, often fixed by age, income level, and/or geography. Aging, income fluctuations, and changing residence are all factors that force clients into transition between agencies. In addition, various types of services are available only in specific locations (Edgar et al., 1987, p. 253).

This history and the collective lack of experience in interagency collaboration greatly increase the difficulty of achieving effective interagency planning and service delivery. However, as a growing body of literature from a number of states and communities demonstrates, it *is* being done. We strongly encourage planners to avail themselves of the experience of others. The frequent enthusiastic willingness of interagency project participants to share their knowledge and energy with others is gratifying. However, we must reiterate that at this time evaluation procedures are not elegant. Few projects have used sophisticated research designs or systematic data collection procedures. In the absence of externally valid (i.e., replicated) outcome data, interagency program strategies should be regarded as current "best practices" rather than data proven techniques (E. Edgar, personal communication, July, 1991).

Second, laying the groundwork for interagency projects through careful planning is all important. Even projects that have focused on individual communities solicited political and fiscal support from state and county governments and involved persons at these levels in the planning process. It is critical to model an interagency attitude by including broad agency representation at the planning stage. Also, money invested in planning team visits to established interagency sites or in consultation by planners representing established programs with influential political and agency figures will yield both short- and long-range benefits—by demonstrating that interagency collaboration is both possible and effective. Planners must think creatively, and encourage those controlling state, county, and agency funds to do likewise. Cost reduction has played a substantial role in the rationale for interagency services to EBD children and youth. While national data concerning the expense of out-of-community placements are influential, data regarding local costs (and projected savings) are more compelling. If agencies must continue to compete for limited funds, or if they even think they must after grant or other seed monies run out, issues involving political turf will never be resolved. Therefore, an early step in the planning process is to bring together diverse groups, educate them regarding the need for and benefits of coordinated interagency services, develop a philosophy of interagency collaboration, and create funding strategies. It remains to be seen whether appropriate community-based services ultimately prove to cost less than a more truncated continuum of services, because thus far the full range of children and family mental health needs has not been addressed by existing programs. As Edgar (personal communication, July, 1991) asserts, community-based interagency programs may not be less expensive than more restrictive treatment options, but they probably are *better* for children and their families.

Third, services must meet child and family needs. These needs supply the focus and the direction that services must take. Therefore, services must follow needs, and funds must follow children and families. The many and diverse needs of children and their families, and the lack of established resources in many areas and communities dictate that interagency case managers and community-based treatment planning teams must be empowered to bring needed services to bear on the problem. With the greater autonomy of this empowerment goes tremendous responsibility. Systems must be developed to assure fiscal and client accountability, including staff training and constructive supervision.

Fourth, successful interagency team building requires systematic and ongoing training. Training should include such topics as awareness of children and families' needs, the issues in meeting their needs, the philosophy and mechanisms of integrated service delivery, and the development of team, case management, and problem-solving skills. Furthermore, training should target all constituents: professional staff, agency administrators, politicians, advocates, parents, and the lay public. An important part of training is a vigorous public relations campaign that informs citizens about the scope of the problem, how the project is addressing the problem, and procedures used to demonstrate fiscal and programmatic accountability. Not only should training be viewed as an important initial component of the program, it should also be ongoing. New staff, parents, and volunteers in particular should be given mandatory basic training, followed by a period of supervision under a qualified mentor. Furthermore, preservice training that emphasizes interagency linkages and collaboration is essential. The lack of good interdisciplinary preservice training for educators, psychologists, social workers, and other helping professionals will undermine efforts to build interagency linkages at the inservice level. Close collaboration among professional disciplines should become a required practicum experience (S. Forness, personal communication, July, 1991).

Fifth, careful thought should be given to where services will be located and how clients will access them. Although public schools should by no means be the only location, this is where the children are (or should be); schools are a logical site for screening, early identification, prevention, and early intervention services. Mandated preschool programs for children with disabilities (and for at-risk populations) and systematic school-based screening procedures for identifying pupils at risk for developing EBD (McConaughy & Achenbach, 1989; Walker, et al., 1988) place schools in an excellent position to implement these important services. Moreover, school buildings offer public space that often goes unused after school hours and throughout the summer months. Although some parents are uncomfortable in school settings, most find the atmosphere there more familiar, if not more friendly, than a mental health facility, for example. If programs that support parents are offered in schools after hours, negative attitudes about schools should be dispelled.

Since many interagency treatment plans will interact with children's educational programs, schools are also a logical place for interagency team meetings. Community agency staff must learn about schools and how their clients behave in school, and educators must learn about other agencies and personnel if these groups are to work well together. These factors should have some effect on the traditional isolation of teaching, encouraging educators to view other professionals as collaborators and resources who share the desire to work toward meeting the needs of children.

Sixth, like training, evaluation must be a fundamental and ongoing part of interagency service delivery. In addition to summative outcome measures that demonstrate the effectiveness and efficiency of interagency programs in meeting children's needs (evaluated against baseline measures of traditional outcomes), formative evaluation procedures should address child progress and consumer satisfaction. Data from formative evaluation should be collected systematically and continuously, and used to modify children's treatment plans, service delivery mechanisms, client goals and objectives, and intervention procedures. The reactions and opinions of professionals who are not on treatment teams but who are in regular contact with clients also should be solicited as part of these feedback loops. The acid test of a system of care, in addition to meeting client's needs, may well be the system's sensitivity to the concerns of the professional community and it's ability to respond to these quickly and appropriately.

Finally, we wish to emphasize that the development of a successful interagency program for children with SED and their families is not an end point. The ultimate success of such programs depends upon the creation of a system of care for *all* children and *all* families in a given community, county, or state. Emerging programs that extend to children and families whose poverty and life circumstances place them at risk for a multitude of problems, including physical or substance abuse, delinquency, pregnancy, developmental delay, physical disease, dropping out of school, unemployment, etc., provide the social and political context needed to support a program addressing this small but needy population. The best way to guarantee an effective system of care for children and youth with EBD is to establish a system of care for people.

Appendices

Appendix A: House Bill 838, General Assembly, Commonwealth of Kentucky

Appendix B: Interagency Resources

Appendix C: Bluegrass IMPACT Memorandum of Agreement and Consent Form

Appendix D: Kentucky IMPACT Case Conference Format

Appendix E: 1991 Annual Report on the Alaska Youth Initiative

Appendix F: Bluegrass IMPACT, Accomplishments to Date

Appendix G: The Ventura Model

Appendix A

House Bill 838 General Assembly, Commonwealth of Kentucky

An Act Relating to Planning and Providing Services to Emotionally Disturbed Children

FRIDAY, MARCH 16, 1990

The following bill was reported to the Senate from the House and ordered to be printed.

AN ACT relating to planning for and providing services to emotionally disturbed children.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

SECTION 1. A NEW SECTION OF KRS CHAPTER 200 IS CREATED TO READ AS FOLLOWS:

The Kentucky General Assembly finds that services to children are provided by various departments and agencies at both the state and local level, often without appropriate policy collaboration and service coordination. The General Assembly declares that the purpose of this Act is to establish a structure for coordinated policy development, comprehensive planning, and collaborative budgeting for services to children with emotional disturbance and their families. It is further the intention of the General Assembly to build on the existing resources and to design and implement a coordinated service system for children with emotion disturbance or severe emotional disturbance that is community based and centered on the needs of the individual child and family.

SECTION 2. A NEW SECTION OF KRS CHAPTER 200 IS CREATED TO READ AS FOLLOWS:

As used in this Act, unless the context otherwise requires:

(1) "Emotionally disturbed child" means a child with a clinically significant disorder of thought, mood, perception, orientation, memory or behavior that is listed in the current edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* and seriously limits a child's capacity to function in the home, school or community.

(2) "Severely emotionally disturbed child" means a child with a clinically significant disorder of thought, mood, perception, orientation, memory or behavior that is listed in the current edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* and that:

(a) Presents substantial limitations that have persisted for at least one (1) year or are judged by a mental health professional to be at high risk of continuing for one (1) year without professional intervention in at least two (2) of the following five (5) areas: "Self-care," defined as the ability to provide, sustain and protect his or herself at a level appropriate to his or her age; "Interpersonal relationships," defined as the ability to build and maintain satisfactory relationships with peers and adults; "Family life," defined as the capacity to live in a family or family type environment; "Self-direction," defined as the child's ability to control his or her behavior and to make decisions in a manner appropriate to his or her age; and "Education," defined as the ability to learn social and intellectual skills from teachers in available educational settings; or

(b) Is a Kentucky resident and is receiving residential treatment for emotional disturbance through the interstate compact; or

(c) The Department for Social Services has removed the child from the child's home and has been unable to maintain the child in a stable setting due to behavioral or emotional disturbance; or

(d) Is a person under twenty-one (21) years of age meeting the criteria of paragraph (a) of this subsection and who was receiving services prior to age eighteen (18) that must be continued for therapeutic benefit.

SECTION 3. A NEW SECTION OF KRS CHAPTER 200 IS CREATED TO READ AS FOLLOWS:

(1) There is hereby created a State Interagency Council for Services to Emotionally Disturbed Children. This council shall be composed of a designee of the state Department of Education and of the following members who shall serve by virtue of their positions: the commissioner of the Department for Mental Health and Mental Retardation Services, the commissioner of the Department for Social Services, the commissioner of the Department for Health Services, the commissioner of the Department of Medicaid Services, and the executive director of the Administrative Offices of the Courts or their designees. The chairman of the council shall be designated by the Governor and shall establish procedures for the council's internal procedures.

(2) The State Interagency Council for Services to Emotionally Disturbed Children shall:
   - (a) Consider issues and make recommendations regarding the provision of services for emotionally disturbed children;
   - (b) Advise each regional interagency council for services to emotionally disturbed children on the effective coordination of services to those children;
   - (c) Develop a form to be signed by the parent or other legal guardian of a child referred to any interagency council for emotionally disturbed children. The form shall enable the agencies involved with the child to share information about the child as necessary to identify and provide services for the child.
   - (d) Review service and treatment plans for children for which such reviews are requested, and provide such advice and assistance as the state council determines to be necessary to meet the needs of emotionally disturbed children referred by regional councils;
   - (e) Assess the effectiveness of regional councils in meeting the service needs of emotionally disturbed children;
   - (f) Advise the Governor and the Legislative Research Commission at least annually, regarding the Commonwealth's service delivery to emotionally disturbed children;
   - (g) Meet at least monthly and maintain records of meetings, except that records that identify individual children shall only be disclosed as provided by law;

(h) Adopt interagency agreements as necessary for coordinating services to emotionally disturbed children by the agencies represented in the state council; and

(i) Develop service programs to meet the needs of emotionally disturbed children.

SECTION 4. A NEW SECTION OF KRS CHAPTER 200 IS CREATED TO READ AS FOLLOWS:

The secretary for human resources, the designee of the state Department of Education, and the executive director of the Administrative Offices of the Courts shall ensure that the State Council for Services to Emotionally Disturbed Children is formed by August 1, 1990. No member of the State Interagency Council shall receive compensation other than that received as a state employee.

SECTION 5. A NEW SECTION OF KRS CHAPTER 200 IS CREATED TO READ AS FOLLOWS:

(1) There is hereby created regional interagency councils for services to emotionally disturbed children. These councils shall be formed in each area development district within the Commonwealth of Kentucky, except that those area development districts that contain a county with a population greater than one hundred thousand (100,000) may form up to three (3) such councils. The regional interagency councils for services to emotionally disturbed children shall be chaired by the district supervisor of the Department for Social Services or a program specialist with expertise in this service area as the district supervisor's designee. Each council shall be composed of the following members: the children's services coordinator from each regional community mental health center or their designee in the case of a multi-council district; one (1) court designated worker chosen by the District Court Judges within the district; one (1) specialist in special education chosen by the school district superintendents in the area served by the regional council. In addition, a regional interagency council for services to emotionally disturbed children may invite any other local public or private agency that provides services to emotionally disturbed children to have a representative become a permanent or temporary member of the council.

(2) No member of a regional interagency council for services to emotionally disturbed children shall be given compensation in addition to that which they already receive as service providers or state employees.

(3) Each regional interagency council for services to emotionally disturbed children shall perform the following functions:

- (a) Review case histories of children referred to it by its members or any other entity within its geographical area to coordinate service provision;
- (b) Initiate and adopt interagency agreements as necessary for providing services to emotionally disturbed children by the agencies represented in the regional council;
- (c) Advise the State Interagency Council regarding service delivery to emotionally disturbed children within the region;
- (d) Refer those children for whom the regional councils cannot provide adequate services to the State Interagency Council;
- (e) Make periodic reports to the State Interagency Council regarding the number of children referred to the regional council and the progress made in meeting the needs of each child;
- (f) Recognize local interagency councils for services to emotionally disturbed children when it determines such a group would be beneficial to service delivery.

(4) The secretary for human resources and the designee of the state Department of Education shall ensure that regional councils for services to emotionally disturbed children are formed by October 1, 1990.

(5) Local interagency councils for services to emotionally disturbed children may be formed as necessary to enhance service provision, better coordinate services, or initiate special projects and fund raising activities for emotionally disturbed children within a city, county, or other local community.

Reprinted by permission, Kentucky Department of Mental Health.

Appendix B

Interagency Resources

The following resource list of people, places, programs, and sources is not meant to be inclusive or evaluative. It provides leads for those interested in obtaining more information.

Documents, Newsletters, Technical Assistance

CASSP Technical Assistance Center
Georgetown University
2233 Wisconsin Ave. NW, #215
Washington, DC 20007
(202)338-1831

Research and Training Center
Regional Research Institute for Human Services
Portland State University
P.O.Box 751
Portland, OR 92707-0751
(503)464-4040

Research and Training Center for Children's Mental Health
Florida Mental Health Institute
13301 Bruce B. Downs Blvd.
Tampa, FL 33612-3899
(813)974-4500

Individualized Care and Other Coordinated Systems of Care

Alaska Youth Initiative
Division of Mental Health and Developmental Disabilities
Box H-04
Juneau, AK 99811

Kaleidoscope
1272 N. Milwaukee, #250
Chicago, IL 61701

Ventura County Children's Mental Health Demonstration Project
300 Hillmost Ave.
Ventura, CA 93003

Vermont CASSP
Department of Mental Health
103 S. Main St.
Waterbury, VT 05676
(802)241-2609

The Willie M. Program
North Carolina Division of MH/MR/SAS
Department of Human Resources
325 N. Salisbury St.
Raleigh, NC 27611
(919)733-0598

Robert Wood Johnson Foundation's Mental Health Services Program for Youth
The Prudential Insurance Company
Group Medical Services Division, GFSO
56 North Livingston Ave.
Roseland, NJ 07068
(201)716-8691

Advocacy Organizations

Center for Law and Education
236 Massachusetts Ave., NE, Suite 504
Washington, DC 20002

Children's Defense Fund
122 C St., NW, Suite 400
Washington, DC 20001

Federation of Families for Children's Mental Health
c/o National Mental Health Association
1021 Prince St.
Alexandria, VA 22314-2971

Mental Health Law Project
2021 L St., NW, Suite 800
Washington, DC 20036

National Alliance for the Mentally Ill
1901 North Fort Meyer Dr., Suite 500
Arlington, VA 22209

National Mental Health Association
1021 Prince St.
Alexandria, VA 22314-2971

Other Groups and Organizations

Invisible Children's Project
National Mental Health Association
1021 Prince St.
Alexandria, VA 22314

NIMH-CASSP
Rm. 7-C-14
5600 Fishers Lane
Rockville, MD 20857
(301)443-1333

Professional Organizations

American Orthopsychiatric Association
19 West 44th St.
Suite 1616
New York, NY 10036

American Psychiatric Association
1400 K St., NW
Washington, DC 20005

American Psychological Association
1200 17th St., NW
Washington, DC 20036

Council for Children with Behavioral Disorders
A Division of the Council for Exceptional Children
1920 Association Dr.
Reston, VA 22091

Mental Health Policy Resource Center
1730 Rhode Island Ave., NW, Suite 308
Washington, DC 20036

National Association of School Psychologists
808 17th St., NW, Suite 200
Washington, DC 20006

National Association of State Directors of Special Education
2021 K St., NW, Suite 315
Washington, DC 20006

National Consortium for Children's Mental Health Services
3615 Wisconsin Ave., NW
Washington, DC 20016

National Council of Community Mental Health Centers
12300 Twinbrook Parkway, Suite 320
Rockville, MD 20852

State Mental Health Representatives for Children and Youth
A Division of the National Association of State Mental Health Program Directors
1101 King St., Suite 160
Alexandria, VA 22314

Funding Information

Child and Family Support Branch
Division of Applied and Service Research
National Institute of Mental Health
5600 Fishers Lane, Rm. 11C-05
Rockville, MD 20857

Division of Assistance to States
Office of Special Education Programs
Department of Education
400 Maryland Ave., SW
Switzer Bldg., Rm. 361
Washington, DC 20202-2720
(202)732-1025

Division of Personnel Preparation
Office of Special Education Programs
400 Maryland Ave., SW
Switzer Bldg., Rm. 35-7-M.S. 2313
Washington, DC 20202-2720
(202)732-1100

Federal Grants and Contracts Weekly
Capital Publications, Inc.
101 King St., Suite 444
Alexandria, VA 22314
(703)683-4100

Grants Management Branch
National Institute of Mental Health
5600 Fishers Lane—Rm. 7C-05
Rockville, MD 20857
(301)443-4414

Other

News Digest (1991). *National Information Center for Children and Youth with Disabilities, 1*(1), 1-15.

Special Net
GTE Educational Services
221 K St., NW, Suite 215
Washington, DC 20016
(800)634-5644

Street, S., & Friedman, R. (1985, March). *Interagency collaborations for emotionally disturbed children. Vol. III: Implementation of interagency agreements.* Tampa: University of South Florida, Florida Mental Health Institute.

Webb, S.L., Maddox, M., & Edgar, E. (1985). *Juvenile corrections interagency transitions model.* Seattle: University of Washington, Experimental Education Unit.

CASSP State Contact List

Department of Mental Health/Mental Retardation Alabama
200 Interstate Park
Montgomery, AL 36193-5001
(205)271-9261

Child and Adolescent Mental Health Division of Mental Health/Developmental Disabilities P.O. Box H-04 Juneau, AK 99811 (907)465-2112	Alaska (local) Kodiak
Coordinator of Rural and Native Services Division of Mental Health/Developmental Disabilities P.O. Box H-04 Juneau, AK 99811 (907)465-3370	
Special Services Division, Human Resources Department Utulei, American Samoa 96799	American Samoa (no CASSP grant)
Children's Behavioral Health Council Department of Health Services 2632 E. Thomas Rd. Phoenix, AZ 85016 (602)255-1030	Arizona
Department of Human Services Division of Mental Health Services 4313 West Markham St. Little Rock, AR 72205-4096 (501)686-9166	Arkansas
Department of Mental Health Division of Community Programs 1600 9th St. Sacramento, CA 95814 (916)323-9289	California
Department of Institutions, Division of Mental Health 3520 West Oxford Ave. Denver, CO 80236 (303)762-4076	Colorado
Department of Children and Youth Services 170 Sigourney St. Hartford, CT 06105 (203)566-8614	Connecticut

Services for Children, Youth, and Their Families Delaware Youth and Family Center Centre and Faulkland Rds. Wilmington, DE 19805 (302)995-8369, ext. 38	Delaware
Child/Youth Services Administration DC Commission on Mental Health Services 1120 19th St., NW, Suite 700 Washington, DC 20036 (202)673-7784	District of Columbia
Department of Health and Rehabilitation Services Alcohol/Drug Abuse/Mental Health Program Office 1317 Winewood Blvd. Tallahassee, FL 32399-0770	Florida
Children's Programs 1317 Winewood Blvd. Tallahassee, FL 32399-0770 (904)487-2415	Florida
CASSP Project, Division of Mental Health, Mental Retardation and Substance Abuse 878 Peachtree St., Suite 315 Atlanta, GA 30309 (404)894-6563	Georgia
Southeast Regional Troubled Children's Committee 516 Drayton St., 4th Fl. Savannah, GA 31401 (912) 234-0130	Georgia Southeast Region (local)
Mental Health, Mental Retardation, and Developmental Disabilities, Human Services Dept. Hoover State Office Bldg. Des Moines, IA 50319-0114 (515)281-4925	Iowa (local)
Children and Adolescent Mental Health Services Department of Social and Rehabilitation Services Docking State Office Bldg., 5th Fl. Topeka, KS 66612 (913)296-3472	Kansas

Wichita Garden Center 415 N. Poplar Wichita, KS 67214 (316) 686-6671	Kansas(local) Wichita
Youth Services Wichita Area Social and Rehabilitation Services P.O. Box 1620 Wichita, KS 67201	Kansas (local)
Children and Youth Services Department of Mental Health and Mental Retardation 275 East Main St. Frankfort, KY 40601 (502)564-7610	Kentucky
Alexandria Mental Health Center P.O. Box 7573 Alexandria, LA 71306 (381)4875611	Louisiana (local) Alexandria
CASSP Project, Human Services Division Bureau of Mental Health P.O. Box 4049, Bin 12 Baton Rouge, LA 70821 (504)342-2548	Louisiana
Mental Health Association in Louisiana P.O. Box 4049, Bin 12 Baton Rouge,LA 70821 (504)342-9528	Louisiana
Children with Special Needs Mental Health and Mental Retardation Station 40 Augusta, ME 04333 (207)289-4200	Maine
CASSP Project Director Governor's Office for Children, Youth and Families 118 North Howard St., Suite 608-A Baltimore, MD 21201 (301)333-4285	Maryland

Child-Adolescent Services
Department of Mental Health
160 N. Washington St.
Boston, MA 02114
(617)727-5500, ext. 529

Massachusetts

HMO-Child/Adolescent Mental Health Project
132 Naples Rd.
Brookline, MA 02146
(617)277-0161

Massachusetts

Somerville Mental Heath Association, Inc.
63 College Ave.
Somerville, MA 02144
(617)623-3278

Massachusetts
Somerville
(ACYF)

Division of Children's Service
Department of Mental Health
320 Walnut Blvd.
Lansing, MI 48913
(517)373-0451

Michigan
(no CASSP
grant)

Child/Adolescent Services
Mental Health Division
Department of Human Services
444 Lafayette Rd.
St. Paul, MN 55155-3828
(612)296-7905

Minnesota
(no CASSP
grant)

Department of Mental Health
1101 Robert E. Lee Bldg.
239 North Lamar St.
Jackson, MS 39201
(601)359-1288

Mississippi

Director, Children and Youth Services
Department of Mental Health
1101 Robert E. Lee Bldg.
239 North Lamar St.
Jackson, MS 39201
(601)359-1288

Mississippi
(local)

Children and Youth Services
Missouri
Department of Mental Health
P.O. Box 687
1915 Southridge Dr.
Jefferson City, MO 65102
(314)751-9482

CASSP Project, Department of Mental Health
Missouri
Division of Psychiatric Services
P.O. Box 687
1915 Southridge Dr.
Jefferson City, MO 65102
(314)751-9482

CASSP Project, Department of Institutions
Montana
Mental Health Bureau
1539 11th Ave.
Helena, MT 59620
(406)444-1290

CASSP Project, Public Institutions
Nebraska
Office of Community Mental Health
P.O. Box 94728
Lincoln, NE 68509-4728
(402)471-2851, ext. 5293

Planning, Evaluation and Program Development
Nevada
Room 600, Kinkead Bldg.
505 E. King St.
Carson City, NV 89710
(702)687-4730

CASSP Coordinator, Community Mental Health Services
New Hampshire
Division of Mental Health and Developmental Services
105 Pleasant St.
Concord, NH 03301
(603)271-5095

Children's Services
New Jersey
New Jersey Division of Mental Health and Hospitals
Capital Center—CN 727
2-98 East State St.
Trenton, NJ 08540
(609)777-0744

Health and Environment Department Behavioral Services Division 1190 St. Francis Dr. Santa Fe, NM 87504 (505)827-2657	New Mexico
New York State Office of Mental Health 44 Holland Ave. Albany, NY 12229 (518)474-8394	New York
Brooklyn Children and Family Services Network 16 Court St., Suite 610 Brooklyn, NY 11241 (718)633-7741 (718) 643-7849	New York (local) Brooklyn
New York State Office of Mental Health 275 7th Ave., 16th Fl. New York, NY 10001 (212)633-4355	New York
Division of MH/MR/SAS Department of Human Resource 325 N. Salisbury St. Raleigh, NC 27611 (919)733-0598	North Carolina (state and local)
CASSP Project, MH/MR/SAS Child and Adolescent Services 325 N. Salisbury St. Raleigh, NC 27611 (919)733-0598	North Carolina (state) (local)
CASSP Project, MH/MR/SAS Child and Adolescent Services Department of Human Resources 325 N. Salisbury St. Raleigh, NC 27611 (919)733-0598	North Carolina (state)
Mecklenberg Area MH/MR/SAS Program 501 Billingsley Rd., Cottage A Charlotte, NC 28211 (704)336-2023	North Carolina (local)

Mental Health Division Department of Human Services State Capital Bldg. Bismark, ND 58505 (701)225-2767	North Dakota (no CASSP grant)
Children's Services Coordinating Council 18th Fl. Capital Bismark, ND 58505 (701) 224-4586	North Dakota
Department of Mental Health 30 East Broad St., Suite 2475 Columbus, OH 43215 (614)466-1984	Ohio
Department of Mental Health c/o Oklahoma Youth Center 1120 East Main St. Norman, OK 73070 (405)364-9004	Oklahoma (state and local)
Program Office for Mental or Emotional Disturbances Department of Mental Health 2575 Bittern St., NE Salem,OR 97310 (503)378-2460	Oregon
Mental Health Office, Division of Children's Services 309 Health and Welfare Bldg. Harrisburg, PA 17120 (717) 783-8335	Pennsylvania
Children and Youth Services Office of Mental Health 308 Health and Welfare Bldg. Harrisburg, PA 17120 (717) 783-8335	Pennsylvania
Office of Mental Health and Retardation 520 North Delaware Ave., Suite 7C Philadelphia, PA 19107 (215)923-4662	Pennsylvania (local)

Department of Health G.P.O. Box 61 San Juan, Puerto Rico 00936 (809)766-1616	Puerto Rico (no CASSP grant)
Division of Children's Mental Health Department of Children and Their Families 610 Mt. Pleasant Ave. Providence, RI 02908 (401)457-4790	Rhode Island
Department of Mental Health Division of Child and Adolescent Services 2414 Bull St. P.O. Box 485 Columbia, SC 29202 (803) 734-7859	South Carolina
Piedmont Center for Mental Health Services 12 Village Plaza West Simpsonville, SC 29681 (803) 963-3421	South Carolina
Division of Mental Health 700 Governor's Dr. Pierre, SD 57501	South Dakota (state CASSP and ACYF)
Northeastern MHC Box 550 Aberdeen, SD 57402 (605)225-1010	South Dakota
Children and Adolescent Services Department of Mental Health and Mental Retardation Doctors Bldg., 706 Church St. Nashville, TN 37219 (615)741-3708	Tennessee
Children and Youth Services Department of Mental Health and Mental Retardation P.O. Box 12668, Capitol Station Austin, TX 78711-2668 (512)465-4657	Texas

CASSP Program, Children and Youth Services Department of Mental Health and Mental Retardation P.O. Box 12668, Capitol Station Austin, TX 78711-2668 (512)465-4832	Texas
CASSP Project, Department of Social Services Division of Mental Health 120 North 200 West, 4th Fl. Salt Lake City, UT 84103 (801)538-4273	Utah
Department of Mental Health Waterbury Complex 103 South Main St. Waterbury, VT 05676 (802)241-2609	Vermont
CASSP Project, Department of Mental Health Program Planning and Development Waterbury Complex 103 South Main St. Waterbury, VT 05676 (802)241-2621	Vermont
Department of Mental Health/Mental Retardation and Substance Abuse Services P.O. Box 1797 Richmond, VA 23214 (804)786-2991	Virginia
Division of Mental Health, Alcoholism and Drug Dependency Services Department of Health #6 7 Estate Diamond Ruby Christiansted, St. Croix, VI 00821 (809)773-1992	Virgin Islands
CASSP Project, Mental Health Division Department of Social and Health Services Mail Stop: OB-42F Olympia, WA 98504 (206)586-3775	Washington

Division of Health and Human Resources West Virginia
1900 Kanawha Blvd., East, Bldg. 3
Charleston, WV 25305
(304)348-0627

Division of Health West Virginia
Office of Behavioral Health Services
1900 Kanawha Blvd., East, Rm. 451
Charleston, WV 25305
(304)348-0627

CASSP Project, Office of Mental Health Wisconsin
Department of Health and Social Services
Division of Community Services
1 West Wilson St.
P.O.Box 7851
Madison, WI 53707
(608)266-6838

Office of Mental Health, Community Services Division Wisconsin
Department of Health and Social Services
Division of Community Services
1 West Wilson St.
P.O. Box 7851
Madison, WI 53707
(608)266-6838

Division of Community Programs Wyoming
Department of Health and Social Services
358 Hathaway Bldg.
2300 Capitol Ave.
Cheyenne, WY 82002-0710
(307)777-7071

Appendix C

Bluegrass IMPACT Memorandum of Agreement and Consent Form

General Provisions

Purpose

This Agreement was developed and entered into by the __________ Board of Education (hereafter referred to as the Board) and the Bluegrass Mental Health/Mental Retardation Board, Inc. (hereafter referred to as the Bluegrass MH/MR Board).

A major goal of the Robert Wood Johnson Foundation grant is to integrate the services of all agencies working with a particular child or family. The purpose of this Agreement is to specify the education and mental health services to be provided to children and youth with severe emotional problems who are nominated for services funded by the Robert Wood Johnson Foundation grant and live within the __________ school district. This Agreement is based on the common interest and shared responsibility for those students whose mental health needs adversely affect their ability to benefit from educational opportunities.

This Agreement does not seek to include all public mental health or educational services available or needed by these students. It is limited to those services which are specified and funded by the grant.

This Agreement conforms to the Education of the Handicapped Act (Public Law 94–142) and amended by Public Law 99–957 and therefore, provides for the least restrictive education appropriate for children and youth with severe emotional problems.

This Agreement is subject to change as the grant funding levels and programs become finalized and as the Kentucky Legislature and Department of Education restructure the state educational system.

The Regional Interagency Council and the State Interagency Council have approved this Agreement and shall monitor its implementation.

Principles of Agreement

Confidentiality

The confidentiality of the student and family is paramount in policy and procedures. At no time shall information about a student be communicated between agencies without written permission of the parents, guardians, or persons exercising custodial control and supervision (e.g., foster parents).

Cost of Services

The costs of services shall be shared between the Bluegrass MH/MR Board and the Board in accordance to the provisions in this Memorandum of Agreement (designated as "The Bluegrass MH/MR Board will:" and "The Board will:" in the following narrative, respectively) and the provisions in applicable state and federal laws.

Transportation

In principle, most mental health services shall be provided in the school. On those occasions when that is not possible (e.g., psychiatric evaluation), transportation during school hours and from school to an after-school treatment program shall be the responsibility of the Board. At other times, transportation shall be the responsibility of the Bluegrass MH/MR Board and family.

Due Process

All students are to be accorded due process. When a student has been identified as needing special education, he/she is eligible for additional due process, as defined by Public Law 94–142 and amended by Public Law 99–457.

Management Information Systems

The Board shall be responsible for management information systems regarding the educational services provided to the student. The Bluegrass MH/MR Board shall be responsible for management information systems regarding the mental health services provided to the student and family. This shall include but not be limited to the clinical record, evaluation reports, and treatment progress notes. This information shall be available through the term of treatment and follow-through, after treatment has been terminated. All information will be exchanged between the district contact person and the service coordinator according to the student's needs and the limits of confidentiality and for the exclusive use of those parties.

Referral

Students may be initially identified by school personnel when severe emotional problems interfere with learning or by other sources (e.g., court designated worker).

Eligibility for services under this agreement shall be determined by the Local Interagency Conference and shall include students who: (1) are severely impaired in at least two of the following areas: self-care, interpersonal relationships, family life, self-direction, and education, (2) have a psychiatric diagnosis that is not solely mental retardation or chemical dependency, (3) have been (or is expected to be) impaired for at least 1 year, and (4) have needs requiring multiagency coordination and treatment planning.

The Board will:

1. Provide one contact person to represent the school district by being a liaison between the Board and the Bluegrass MH/MR Board and to process referrals for grant-funded services.
2. Conduct a referral conference which shall involve at least the district contact person, local school representative, and the student's parent(s) in order to inform the parent(s) about the grant-funded services and to secure permission to release information about the student for the purpose of making the referral to the Bluegrass MH/MR Board for grant-funded services.

The Bluegrass MH/MR Board will:

1. Provide a local resources coordinator, who shall receive information about a referral, coordinate the eligibility determination, assign and supervise the service coordinator, and access crisis services as needed.
2. Provide a local resources coordinator, who shall conduct the Local Interagency Conference to determine eligibility for services under this agreement. In accordance with the needs of the student this shall include other agencies, such as education, Department for Social Services and Comprehensive Care Center.
3. Cause the local resources coordinator to assign a service coordinator, who will be responsible for coordinating the assessment, treatment, and follow-through for students who are eligible for services under this agreement.
4. Cause the local resources coordinator to immediately assist an eligible student, who is in a crisis, through the flexible response

team—for example, with crisis intervention, wraparound, or respite services.

5. Cause the local resources coordinator to assure continuity of services by referring the student, who is not eligible for services under this Agreement, to other resources in writing.

Assessment

Students who are eligible for services under the auspices of this Agreement shall have a service coordinator, who shall assist in securing the assessments necessary for adequate treatment planning.

The Board will:

1. Provide priority assessment (i.e., within 20 work days) of intelligence, academic achievement, and adaptive skills by an appropriately certified or licensed psychologist/psychometrist. Assessments completed within the last calendar year may be acceptable for this purpose.
2. Provide feedback by telephone to the service coordinator within 5 work days of the assessment and written feedback within 20 work days.

The Bluegrass MH/MR Board will:

1. Provide a service coordinator to coordinate the assessment process and report to the local resources coordinator.
2. Provide through the local community mental health center priority (i.e., within 20 work days) assessment of emotional condition and family dynamics by a master's level mental health professional, or doctoral level psychologist or psychiatrist, with telephone feedback within 5 work days and written feedback within 20 work days.

Treatment Planning

Once the necessary assessments are secured, the eligible student shall receive an individual educational plan (IEP) for special education services, when appropriate, and a treatment plan for mental health services to be provided in the school and community. The treatment plan shall also include a crisis intervention plan for when the student presents a clear and present danger to self or others or whose behavior presents a severe impediment to other students' ability to learn. The treatment plan is formulated by the service coordinator and other members of the local interagency conference (e.g., parents, district contact person, local school representative, mental health professional, and representative of the Department for Social Services) and may be modified in accordance with the student's needs in subsequent meetings of the Local Interagency Conference.

The Board will:

1. Participate in a preliminary planning meeting and the local interagency conference through the district contact person and local school representative for all grant-eligible students.
2. Create an individual educational plan, which includes special education services, and also a treatment plan, which includes mental health services, for students eligible for grant-funded services and special education services.

The Bluegrass MH/MR Board will:

1. Cause the local resources coordinator and local interagency conference to determine if the student is eligible for services under the auspices of this agreement based upon the completed assessments.
2. Provide eligible students with a treatment plan derived during a local interagency conference.
3. Cause the noneligible student to be referred for other services with a written list of resources appropriate to the student's needs.

Intervention

Intervention for eligible students will be provided in the school and community in accordance to the IEP and/or treatment plan. Mental health services will be coordinated by the service coordinator.

The Board will:

1. Provide regular education and special education services as outlined in the IEP and/or treatment plan (which were in part formulated by school personnel).
2. Provide in-school discipline as outlined in the IEP and/or treatment plan, which includes the crisis intervention plan.
3. Contact the service coordinator when a student's behavior presents a clear and present danger to self or others or a severe impediment to other students' ability to learn.
4. Assist in modifying the treatment plan as needed in order to provide continued educational and mental health services.

The Bluegrass MH/MR Board will:

1. Provide mental health services as outlined in the treatment plan.
2. When appropriate, provide the services of the school-based treatment team. These may include, but are not limited to, consultation, counseling, training, assisting the teacher, and assisting peer integration.

3. When appropriate, provide the services of the flexible response team. These may include, but are not limited to, crisis intervention, wraparound, and respite.
4. Provide access to other grant-funded programs as needed, which may include but are not limited to after-school program, day treatment, respite, intensive in-home, and therapeutic foster care.
5. Facilitate access to other community resources, such as other services of the community mental health center, recreation, and others.
6. Provide the service coordinator to continuously monitor services and help modify the treatment plan as necessary.

Follow-Through

During the intervention phase the student's progress will be monitored by the service coordinator and reported to the local interagency conference. The student's emotional condition and behavior may change to indicate that planned intervention in the school and community is no longer appropriate, either due to improvement or regression. Follow-through allows a continuity of care either to long-term statistical tracking (after substantial improvement) or to more intense, restrictive services (after substantial deterioration).

The Board will:

1. Provide the district contact person and local school representative to participate in the local interagency conference, which reviews the student's progress and needs.

The Bluegrass MH/MR Board will:

1. Provide the local resources coordinator and service coordinator for the local interagency conference, which shall include the parents as well as other involved agencies.
2. Cause the placement review committee with the service coordinator to determine the necessity of more intense, restrictive services (e.g., inpatient hospitalization), when the student's emotional condition and behavior have deteriorated to the point that school and community interventions are no longer appropriate.
3. Cause the service coordinator to facilitate the referral to more intense, restrictive services and to participate in admissions and discharge planning.
4. Cause the service coordinator to facilitate the transition from more intense, restrictive services back into community-based services through the local interagency conference.

5. Refer the student to appropriate community resources and long-term statistical tracking, when the student's emotional condition and behavior have improved to the point of no longer needing grant-funded services.

Effective Date of Agreement

This agreement shall become effective when signed by the Superintendent of the __________ Board of Education and the Executive Director of the Bluegrass Mental Health/Mental Retardation Board, Inc. It is to terminate 1 year from that date, subject to renewal. This Agreement may be canceled by either party upon 30 calendar days written notice to the other.

If, during the term of this agreement it is deemed necessary by either party, the Agreement may be reviewed and revised by mutual agreement.

This Agreement may be continued beyond the termination date with written agreement by both parties.

____

Superintendent of the Board   Date

____

Executive Director,   Date
Bluegrass Mental Health/Mental
Retardation Board, Inc.

Bluegrass Impact Consent to Treatment and Consent for Release of Confidential Information: Bluegrass Interagency Mobilization for Progress in Adolescent and Children's Treatment Interagency Information Exchange

I, ______________________________, hereby declare that I am the parent _____ or guardian _____ of ______________________________, who is a child (SS# __ __ __-__ __ -__ __ __ __) applying for services provided by Bluegrass IMPACT, a project of the Cabinet for Human Resources and the Bluegrass Regional Mental Health/Mental Retardation Board, Inc. I hereby give permission to those agencies or providers affiliated with Bluegrass IMPACT, a listing of which has been given to me, to provide services to my child including consultation with agencies which may not have had direct contact with my child.

I recognize that the services for my child's condition require the collaboration of numerous agencies and service providers. I understand that this collaboration requires the disclosure of information about my child so as to help the various service providers to make necessary assessments and service plans.

I understand that the following information may be released to service providers:

1. The full name and other identifying information regarding my child and our family.
2. Diagnostic and assessment information including psychological and psychiatric evaluations, medical histories, and educational and social histories. These evaluations may include references to other family members.
3. Treatment and/or education rehabilitation or habilitation plans.
4. Current observations of behavior.
5. Recommendations to other providers.
6. Periodic follow-up on non-accepted child.

The purpose of this disclosure shall be to facilitate service delivery to my child.

I further understand that the information generated or obtained by the project can be shared with the agencies or providers affiliated with the project.

This authorization to release information extends to the various interagency committees and response teams of project IMPACT. I authorize data to be shared with the Cabinet for Human Resources, Department for Mental Health and Mental Retardation Services, Division of Mental Health. The purpose of this disclosure is to assist in needs assessment and planning for future services.

I also understand that this authorization for release of information will be in effect for the duration of services provided to my child and will expire upon termination of services. I understand that I can revoke this consent at any time and this consent shall be reviewed annually.

Affiliated Agencies and Providers

____ Department of Social Services
____ Division of Mental Health
____ Comprehensive Care Center
____ Kentucky court system
____ School districts: ____
____
____ Health departments
____ Urban county government children's services
____ Private therapist: ______________________________________
____ Psychiatric hospital unit: _______________________________
____ Therapeutic group home: ________________________________
____ Other: ____
____
____
____

I certify that I have read and understood the content of this form.

____
Parent or Guardian Date

____
Witness Date

REVOCATION REQUEST:

I hereby revoke the authorization for release of information pursuant to the terms above.

____
Parent or Guardian Date

____
Witness Date

Reprinted by permission, Kentucky Department of Mental Health.

Appendix D

Kentucky IMPACT Case Conference Format

The 1-Hour Child Specific Service Team Meeting

The service coordinator prepares parents and professionals before the meeting, facilitates the meeting, and records the results on chalkboard, newsprint, or eraser board.

5 mins	Introductions, description of the meeting structure, reminders about the ground rules, signing of the confidentiality agreement.
10 mins	The parent or the referring agency presents key information about the child and situation (uninterrupted); the decision about whether the parent or agency should make the first presentation must be carefully made in advance and must reflect the needs and wishes of the parent.
3 mins	Follow-up questions and clarification (not challenges or disagreements)
5 mins	The parent, the referring agency, or another agency representative presents additional, previously uncovered information (uninterrupted); if the parent has not presented first he or she should do so this point, unless some other choice has been made.
3 mins	Follow-up questions and clarification (not challenges or disagreements).

(Repeat the 5-minute presentation followed by 3 minutes of follow-up for each additional agency or member, to a maximum of 30 minutes.)

10 mins	Identify and make a visible list of the important issues (brainstorming process).
15 mins	Create and visibly record an interagency service plan, taking each important issue from the brainstorming and recording information on poster-size paper in the following format:

Tasks (What)	**Assignment (Who)**	**Due Date (When)**	**Comments**
Begins task statements with action verbs			

(More time will be available for case planning in most conferences, because presentations will not fill the first half hour.)

5 mins Complete the written plan, summarize it, remind people of assignments, set the next meeting date (if necessary) and give the team a sense of closure.

KENTUCKY IMPACT'S 1-HOUR MODEL
Facilitation Child-Specific Service Team Meetings
By Vicki Phillips, Kentucky Department of Education

Prior to Meeting:

_____ 1. Notify/confirm with referral source and core team members the meeting date, time, and location.

_____ 2. Invite as appropriate family members, the child/youth and any auxiliary personnel whose experience/expertise could lend to the decision making regarding this particular child.

_____ 3. Provide referral source and invited family or auxiliary personnel with a brief summary (written or verbal) of the type of information that the team will be requesting.

During the Meeting:

Team Business

_____ 1. Conduct necessary team business or restricted discussion prior to considering the facts of the situation.

_____ 2. Identify team members' roles:
   a. The service coordinator will typically facilitate the meeting (sometimes the local resource (LRC) coordinator is relied upon to fill this role).
   b. The service coordinator charts the "issues" and "service plan" portions of the meeting.

c. Select one team member to cue support and encouragement of the family/child throughout the meeting and the facilitated process.

Discuss Coordinated Services

_____ 3. Begin discussion: break ice, establish a positive climate, introduce team members.

_____ 4. Review purpose of the meeting: state the goals of the session informally; briefly outline the format in which the meeting will be conducted including the ground rules, the allotted time frames, and the need for adherence to the process.

Service Analysis

_____ 5. Request specification of the problem. (It is important that the team attend, focus, and listen.)

Presentation Content

- Current status of situation/presenting problems
- Essential history
- Family dynamics/agency interactions with options already explored/exhausted

Setting Variables	**Child/Family Specific Behaviors (including strengths)**	**Response Variables**

Presentation Format

Referring agency or family/auxiliary members:
    10 uninterrupted minutes for problem specification
    3 minutes for follow-up questions/clarification
Other agencies or family/auxiliary members:
    5 uninterrupted minutes for problem specification

_____ 6. Identify and list predominant issues succinctly; seek verification from team. (Note: Visibly record issues—e.g., chalkboard, dry eraser board, poster board.)

- Use round robin/"shout out" technique—no discussion
- Focus on strengths as well as presenting problems

Service Plan Design

_____ 7. Discuss previously formulated issues in the form of tasks to be accomplished; first consider "immediate need" issues.

Task (What)	**Assignment (Who)**	**Due Date (When)**	**Comments**

If potential solutions do not immediately materialize in the form of existing programs/services (in other words, if you get stuck or find a need to get creative) try:

- Taking one issue at a time (immediate need; predominant issues first) and "brainstorming" the range of potential ways to intervene:

  Use the rules for "brainstorming"

  Consider potential for changing the setting variables, the behavior, and/or the response variables

  Do not be agency specific

  Brainstorm first the potential interventions, and then the dynamics within which such an intervention might materialize (e.g., potential providers, potential funding sources)

  Get creative—explore all the possibilities

- Choosing from the brainstormed list the two or three most workable/feasible possibilities and,

  Design related tasks for the service plan

  Assign a team member or the LRC the task of further exploration

- Considering whether a service might be "built" for this particular situation that might impact a broader "pool" of children/youth with similar needs and thus warrant additional consideration, planning, and advocacy.

Closure

_____ 8. Verbally summarize the major points of the service plan including individual team member responsibilities.

_____ 9. Schedule a date for follow-up.

_____ 10. Transfer service plan from chart (maintain issues list for follow up purposes)—provide copies of plan to conference participants.

AFTER THE MEETING

_____ 11.

_____ 12.

_____ 13.

Reprinted by permission, Kentucky Department of Mental Health.

Appendix E

1991 Annual Report On The Alaska Youth Initiative

In 1985, senior staff in the state of Alaska's Department of Education and Department of Health and Social Services realized that they had a problem: both departments were sending increasing numbers of emotionally disturbed youth to services outside of Alaska. At that time, an interdepartmental committee was formed to address growing pressure from schools, child welfare, and juvenile justice offices to send even more youth out of state. This committee, the Interdepartmental Team (IDT) was composed of senior staff from the state-level offices of the Department of Family and Youth Services (DFYS), the Department of Education (DOE), and the Division of Mental Health and Developmental Disabilities (DMHDD). Out of this committee's work, the Alaska Youth Initiative (AYI) was formed, and will shortly reach its fifth birthday.

The AYI program is now serving more than 65 youth, and has an unfunded list of 15 youth. Currently, no youth returned from out-of-state placement have had to return to out-of-state care, no DOE youth have been placed out for over 4 years, and no DFYS youth placed out for almost 2 years.

Important points to know about AYI include:

1. The need for AYI services is growing over time.
2. Minorities (Alaska natives and other minorities) are now the majority of AYI youth.
3. AYI has learned that when "the adults disagree, the kids fail." Therefore, effective service must involve a process to help education, mental health and social services agencies work together on a local *and* state level.
4. The cost of serving AYI youth in-state is only a fraction of the cost of out-of-state care. Over 125 new private-sector jobs were created with the same funds we used to send to other states.

After years of using program models from other states, Alaska is now seen as an initiator of program models. AYI is being replicated in many other states and is recognized nationally as one of the most important interagency efforts for children with severe emotional problems.

Alaska Youth Initiative Annual Report, January 1991

History

Senior staff in the Alaska State Departments of Education and of Health and Social Services realized in 1985 that they had a problem with sending increasing numbers of emotionally disturbed youth to services outside of Alaska. This practice was identified as a problem for a variety of reasons, including cost, questionable results, and legal and ethical issues.

Alaska is only one of many states that regularly sent their most troubled youth outside of their states to receive services. In the past, Alaska has had up to 200 youth in out-of-state care at one time. This number was reduced to approximately 90 youth by development of in-state residential facilities during the late 1970s. During the early 1980s, the number of youth in out-of-state care (DHSS and DOE) fluctuated between 90 and 40, depending on the available budgets. At times during difficult budget cycles, youth were brought back from placements and put back into their communities without additional services. Other youth turned 18-years-old in out-of-state care and voluntarily or involuntarily returned to Alaska.

In 1985, an interdepartmental committee was formed to address the problem. This committee was composed of senior staff from the state-level offices of DFYS, DOE, and the DMHDD. Out of this committee's work, the Alaska Youth Initiative (AYI) was formed.

A New Services Model

In the traditional "categorical" model of services, children are brought into pre-existing programs and intervention models. When their needs are not met, they are referred elsewhere. In an "individualized" model of services, an interdisciplinary team (including the parent) sits down and asks the question, "What does this youth need so that he or she can get better?" The team looks at not only the medical areas, but family, friends, vocational, educational, psychological, safety, economic, and other areas of need. The team agrees that they will offer the youth unconditional care. This means that if his or her needs are not met, the individualized program will be changed, and that the youth cannot be "kicked out." Individualized services programs such as AYI are neither totally state run nor totally privately run, but are partnerships of state and private agencies.

The individualized model, often called wraparound services, has been replicated and refined in many places in the U.S. over the last several years. In the *Journal of Mental Health Administration* (Spring, 1990), in an article titled "The Role of Individualized Care in a Service Delivery System for Children and Adolescents with Severely Maladjusted Behavior," John Burchard and Richard Clarke said "The most impressive demonstration of the approach is the Alaska Youth Initiative (AYI), where, after two years of individualized care, almost all of the children who were in residential treatment programs out of state are now in less restrictive programs in Alaska."

Significant Program Outcomes

The principal original goals of AYI (from 1986) were to:

1. "Limit further inappropriate institutional and out-of-state placements." **The outcome:** The flow of youth going to out-of-state placements has been stopped. Only two AYI youth (out of more than 117) have had to be placed out-of-state, and both of those were in the first 2 years of AYI. Each of these youth later returned to AYI.
2. "Transition back our youth who have been placed out-of-state." **The outcome:** There is only one youth still outside in legitimate placement. (Three other youth are out, but will not return because their parents have moved out of Alaska.) *No youth who was returned to Alaska through AYI has had to go back out again.*
3. "Provide special individualized case planning, monitoring, program development, and funding for youth and their families." **The outcome:** AYI is nationally recognized as the leading program in this area of services, and the individualized model has now expanded to services for persons with developmental disabilities and to adults with severe mental illness. The individualized model of services is now recognized as a viable alternative to institutionalization.

Other Outcomes

Figures 2 through 8 illustrate important information about the AYI youth. Other data about actual treatment outcomes (reduction of the need for hospitalization, number of days spent in community of residence, and other indicators of health) will be issued in supplemental form as soon as possible. In addition, the final results from the "Annual Independent Review" study for fiscal year '90 are in the final stages of completion and will be issued soon. This study was an intensive case study review of 11 selected youth.

"Point In Time" AYI Outcome Rating

In 1990, the state AYI coordinator and each of the local AYI coordinators were asked to rate all youth who had been in AYI at least 6 months (81 out of a total of 95 AYI-eligible youth). The youths' cases were rated (3 to 0) regarding each of two question. From a "successfulness" question and an "instructiveness" question, a composite score (total possible=12) was obtained and all 81 youth were then rank-ordered. When the successfulness question was studied in isolation, a composite total score of 6 was possible. The instructiveness rating (i.e., how much did these youth teach AYI about doing individualized services?) was used to select the 11 youth who were chosen to be subjects of the "Annual Independent Review." The question on successfulness was asked in the following manner:

Question: Successfulness: How "successful" do you think the individualized services approach was for this case?

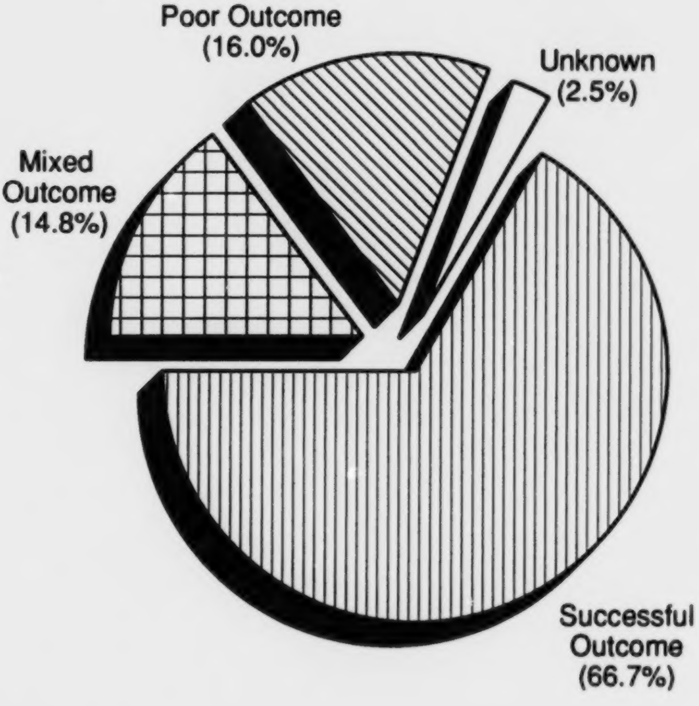
Where: 3 = Successful outcome
2 = Mixed outcome
1 = Poor outcome
0 = No information/unknown

To increase understanding of this characteristic, a list of example questions was offered for the respondent to consider while she or he rated the youth. For instance, a question regarding successfulness was "Did the youth achieve a more stable, longer-enduring life style?"

The results showed that the state and local coordinators, in composite, rated 67% of the cases as having had a successful outcome, 15% as having had a mixed outcome, and 18% as having had a poor or unknown outcome. (See Figure 1.) The results were based on a total of 81 cases that either had already been archived, or had been active at least 6 months.

This preliminary information suggests that AYI's individualized services effort has had a considerable impact. Overall, 67% of the rated youth were considered to have experienced a successful outcome. In addition, another 15% were considered to have had a mixed outcome. This is a remarkable result given the extremely challenging nature of the youth who were served, and the many extremely negative prognoses virtually all of these youth had been given.

FIGURE 1
Success Rating for Youth in AYI as of Spring 1990



Ultimately, what these rating scale data mean is related to the issue of external validity. That is, what are the other measures or means that can be used to independently corroborate that the reported perceptions of the raters reflect a clinical reality for these youth? In part, close examination of the "Annual Independent Review" data will be used to help examine the validity of these data.

Questions and Answers

The following are commonly asked questions and answers about AYI.

1. **Q. What are the features of effective individualized services?**

   A. AYI has identified ten principal features of individualized services for youth with severe emotional disturbance and/or mental illness. Such a service functions by:
   1. Building and maintaining normative lifestyles.
   2. Insuring that services are client-centered.
   3. Providing unconditional care.
   4. Planning for the long term.
   5. Working toward less restrictive alternatives.
   6. Achieving provider competencies.
   7. Establishing consensus among key decision makers.
   8. Funding services with flexible budgets.
   9. Installing a "gatekeeper" function.
   10. Developing measurable accountability.

2. **Q. Why should we put so much money into one youth when we could offer services to many more less-disturbed youth for the same amount of money?**

   A. The state must serve these youth. Alaska statutes and the state mental health plan clearly say that the state has responsibility. It is the sad truth that less than 5% of the youth consume 80% of the total funds available. There is no legal way to avoid serving the most disturbed youth first.

3. **Q. Does admittance into AYI mean that I will have no further involvement with the referred youth? (A question that is frequently asked by DFYS probation officers or social workers.)**

   A. You will still be involved in the case. Admittance into AYI means that the youth referred will have an interagency team, additional case management, flexible funds, and individualized planning. Legally, DFYS can still make the final decisions about the youth, but experience has shown that youth are best served when a team operates on a consensus model. AYI has learned that when "the adults don't agree, the kids fail."

4. Q. **Why should schools, mental health centers, or DFYS mess with AYI? Why don't our schools, mental health centers, or DFYS offices just do their own individualized services?**

   A. In fact, AYI would like to see more schools, mental health centers, and DFYS offices start creative individualized planning around given youth. For example, the reason many AYI youths are in AYI is simply that they were heading out of state because no therapeutic foster homes or other basic services were available. In many states, schools, mental health centers, and DFYS-type agencies have flexible funding arrangements, interagency teams, and expanded services to allow staff more freedom in planning for youth.

   However, there will always be a number of youth who "blow through" all services due to extreme needs, are likely to need larger budgets than one agency can fund alone, and who need the extensive case-management, unconditional care, smaller case load size, interagency teams, and state-level planning that AYI provides.

5. Q. **Sometimes it seems like interagency work is more trouble than it is worth. Why not just run everything through one agency?**

   A. Yes, interagency work is often more difficult to implement than running programs with only one agency. Single-agency work is less complicated and perhaps more efficient to administer. However, these youth and their parents live out there in a complicated, messy world, have multiple and complex needs, and are not served well by a single agency effort that cannot address that complex world. Therefore, effective services must involve schools and multiple agencies working together on a local *and* state level. This work is rarely easy. There are "turf" wars, money arguments, and other turmoils, but the extra effort results in better services for our youth.

   Governor Walter Hickel has recently ordered the departments and their divisions to begin working together as a routine part of their business. AYI, although certainly not problem-free, is the most extensive interagency program ever initiated by the Departments of Education and of Health and Social Services. Before Congress, in October 1990, in House debate on a national mental health bill (S. 2628), Rep. George Miller (D-CA) cited the AYI program as being a leading national model in coordination of services to children with serious emotional and mental disorders.

6. **Q. Wouldn't these youth be better off in out-of-state institutions.**

   A. No. A number of recent court decisions in the lower 48 have reinforced the idea that most out-of-state placements may even be illegal. The bottom line is that we cannot institutionalize youth in Alaska except under strict conditions and then only for brief periods of time under direct court order. Sending youth far from home and family may only serve to get around Alaska's laws, which is clearly not a good idea. The National Mental Health Association recently completed a major investigation called "Invisible Children," which was an exposé on the practice of out-of-state placements, and called for all states to bring their children home.

   In addition, close examination of the effectiveness of out-of-state placements shows that although youth may stabilize in a locked environment, these changes rarely maintain when these youth return to Alaska. On the other hand, AYI has shown that often the same youth can be served in his or her home environment and maintain gains over time. Incidentally, replications of AYI in other states are finding basically the same answers to this question.

   Sending our children to other states means more than poor treatment outcomes. It means we are sending our money and our jobs to other states. Without AYI, over 125 Alaskan private-sector jobs would be in jeopardy as once more, we would begin to employ Texans and Californians to take care of our children. Alaskans are now employed to serve AYI youth with approximately the same amount of money that we formerly allocated to send youth to Texas, Oregon, and other states.

7. **Q. Isn't it really cheaper to send youth out-of-state?**

   A. No, out-of-state placements now cost over triple the cost of AYI interventions, are often in clear violation of the Indian Child Welfare Act (over 45% of AYI youth are Alaska natives) and are considered to be in violation of the rights of the youth to the least restrictive treatment alternative (see Figure 7).

8. **Q. I know an AYI youth who isn't doing well. How can you say this is a good program?**

   A. Admittance into AYI does not mean instant cure, or that miracles will happen. AYI intervention does not instantly reverse years of problems. In fact, some youth may go through many configurations of services prior to finding the right intervention package.

AYI has been a unique developmental effort, without any other models to look at. AYI has launched an effort to ensure that the lessons learned during the demonstration period are now put into practice on a statewide basis, and enormous effort has been put into improving the program. The reality is that no program, no DFYS office, school, or mental health center is perfect, and AYI is no exception.

9. **Q. Aren't AYI foster parents paid too much?**

A. No. To get into AYI, a local and a state interagency team needs to agree that the youth is one of the most disturbed in the state. Therefore, anyone delivering foster care can expect to have a youth who proves to be very difficult to live with and to commit to serving. If the youth were not in AYI, he or she would be in a service that costs several times what the entire cost of AYI is. It makes no sense to try to save money on foster care and then spend far more money to institutionalize the youth. AYI is presently exploring the use of the new DFYS youth severity rating scales to make the foster care rates more consistent on a statewide basis.

10. **Q. AYI youth all have mental health problems; why isn't mental health (DMHDD) more responsible?**

A. In the past, there is no doubt that DMHDD did not meet the challenge of serving high-risk youth and that DFYS and schools have consequently born the burden of service for these youth. However, in 1986, DMHDD made a commitment to change this, and AYI was the first effort attempted. Since 1986, DMHDD has funded many new programs to serve priority youth all over the state, although the new programs cover less than 8% of the youth in need. DMHDD data show that over one-half of the youth served in these new programs are DFYS custody youth.

The new state Mental Health Plan calls for far greater expansion of these services, but they will still depend on legislative appropriation, regardless of what the plan says.

11. **Q. Is DFYS spending more money now on these youth than before AYI?**

A. No. At the start of the AYI effort, DFYS was spending annually approximately the same amount of funds in out-of-state services that they now have in AYI and to serve the few remaining youth who are in out-of-state services. In 1986, DFYS spent this amount of money to serve 23 youth out-of-state. Now, the same amount of funds serves more than 55 DFYS youth through AYI (the four youths still out are slated to return) because DMHDD has shared the cost of serving the youth (or paid the entire cost), and because in-state AYI services are far cheaper than out-of-state care (see Figures 7 and 8).

12. **Q. How do I refer a youth to AYI?**

    A. The state level Interdepartmental Team (IDT) will review referrals from school districts, community mental health centers, DFYS offices, or the Alaska Psychiatric Institute. Please write to AYI/DMHDD at Box H-04, Juneau, AK 99811, for a complete referral packet.

13. **Q. Are there still Alaskan children in out-of-state care? Why, and how much do they cost?**

    A. There are still four children in out-of-state care. Three of them will not be returning to Alaska because their families no longer live in Alaska. It is often difficult to get the new states to pick up custody of the youth, but AYI is in the process of planning individually for the youth in the states where their parents live. The one youth who will return to Alaska will do so in June.

    The bad news is that the youth still outside cost over $400 per day, per child (total of $584,000 per year). The good news is that it has been over 4½ years since the DOE sent any youth outside, and almost 1½ years since DFYS has sent youth out (except for one youth who was sent out and returned after one month).

14. **Q. What evidence do we have that AYI is a good effort?**

    A. Even though much work remains to be done, after a 5-year developmental period, the Alaska Youth Initiative program is being widely recognized as a national and international model for serving youth who have severe emotional disturbance and/or mental illness.

    In the *Care of the Seriously Mentally Ill: A Rating of State Programs*, 1990, E. Fuller Torrey, M.D. and colleagues promoted AYI as a promising development. Torrey said:

    "Services to seriously emotionally disturbed children in Alaska have been closely watched by child mental health advocates nationwide. The reason is that for the past few years, the state's Department of Health and Human Services and the Department of Education have been operating the Alaska Youth Initiative (AYI), an ambitious program to bring home the numerous children sent out of state due to a lack of services in Alaska. AYI emphasizes flexible services that are tailored to the needs of each child; the program's funds can be used to purchase virtually any service that a child needs to remain stable and at home."

The Research Triangle Institute, under contract with the federal government, visited sites and researched ten states that had received major federal grants to modify services to children (including Alaska). Of the ten states, only Alaska was judged to have achieved or made substantial progress toward five of the six major goals of the grant program, and to have made some major progress toward the sixth and final goal of the program. These results were published in a document titled *The CASSP Initial Cohort Study, Volume I: Cross-Site Findings.* After interviewing a wide cross section of Alaskan "stakeholders" such as agency personnel, local program staff, and parents of youth with serious mental illness, the Research Triangle Institute staff concluded that:

"Interagency coordination in Alaska at the time that the CASSP project started is generally acknowledged by stakeholders to have been minimal. Stakeholders were unanimous in the view that interagency coordination has improved over the past five years, and most attribute that improvement to the experience gained in AYI."

The National Institute of Mental Health recognized AYI as one of six nationally most-influential children's services efforts through funding of a major research project, which is titled "Alternatives to Residential Services." Also, last year at the Tri-Discipline Conference in Anchorage, AYI was named the "Mental Health Program of the Year."

In addition, government staff in the following 34 areas have requested and received extensive training on AYI (via on-site training or by teleconference. AYI staff have done this on their own time):

District of Columbia; Nebraska; Vermont; Maine; Maryland; Florida; Hawaii, Pennsylvania; West Virginia; Ohio; Kentucky; Minnesota; Wyoming; Missouri; Illinois; California; Oregon; Washington; Idaho; Montana; Colorado; Utah; Oklahoma; Arizona; Nevada; North Dakota; Guam; Virgin Islands; New Hebrides; Australia; Hong Kong; Tahiti; American Samoa; Saskatchewan, Canada. In addition, the former Alaska Commissioner of Health and Social Services presented translated AYI program descriptor materials to health authorities in the Soviet Union on a state visit in 1988. In 1989, AYI staff presented the program on a national public television program titled "State to State."

Unfunded Youth

Unfortunately, the number of extremely disturbed youth in Alaska is increasing. The social need for foster care, residential services, juvenile justice, child protection, special education, drug rehabilitation, community mental health services, psychiatric hospital resources, and other services is growing. The referral rate to AYI has grown faster than the available resources. AYI does not keep a traditional waiting list, but instead reviews the referrals and enters them on a list of "unfunded" youth if they are deemed eligible for AYI. A team is formed to put together a tentative plan and budget for the youth so that the IDT can inform the appropriate division directors of the status of the fiscal need. Based on the types of youth that are being referred, the intensive needs of Alaska's most disturbed youth are clearly going to continue to grow (see Figure 2).

FIGURE 2
AYI Acceptance and Archival Rates by Fiscal Year

This figure shows the rates of acceptance of youth into AYI. This shows that, across time, the need for services is growing. The only way to serve additional unfunded youth is by increasing discharges, limiting costs, or developing other services.

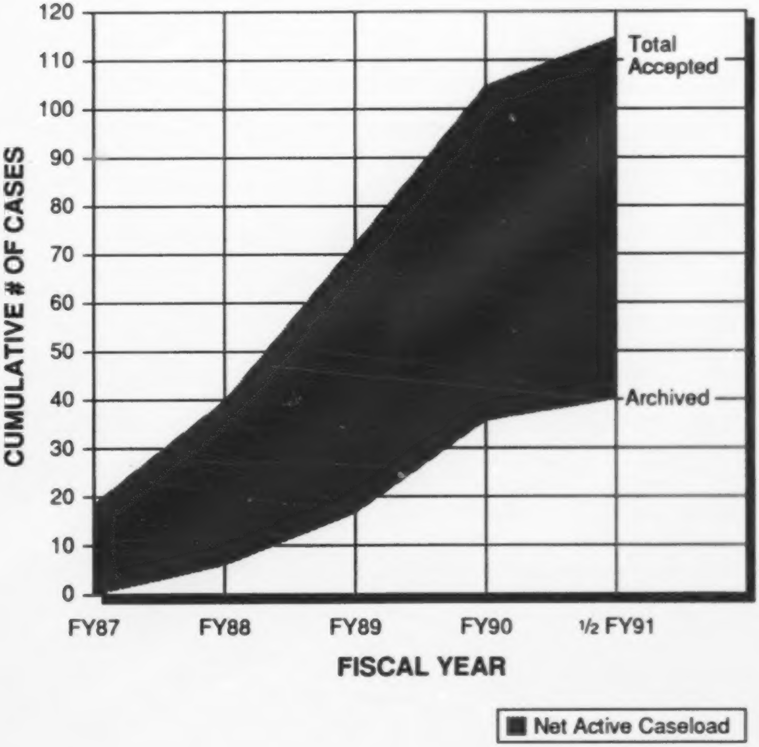


FIGURE 3
Ethnicity of 117 AYI Youth

This figure shows that minorities are now the majority in AYI.

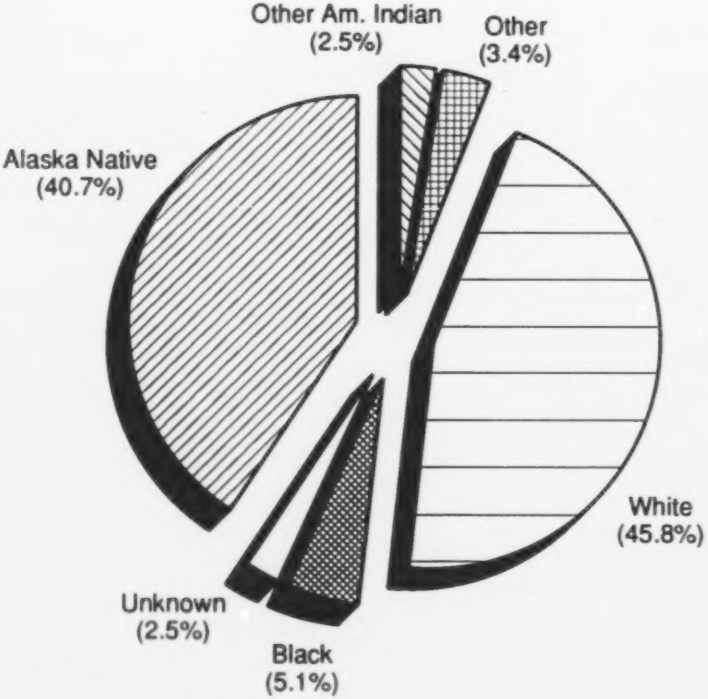


FIGURE 4
Age at Acceptance of 116 AYI Youth

This figure shows that youth are being referred to AYI at a younger age.

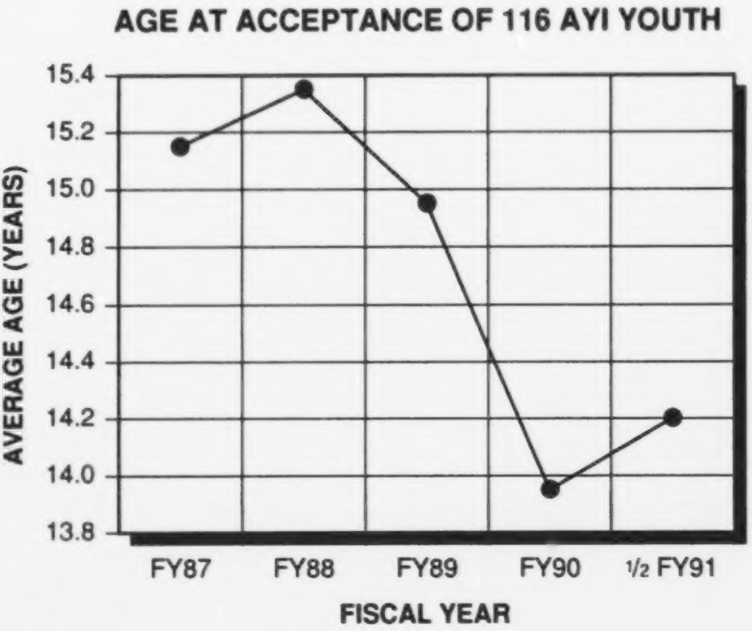


FIGURE 5
AYI and IDT Funding by Agency
(Youth Who Are Active and Funded *N* = 62)

This figure shows the amount of funds contributed to AYI for fiscal year '91 by each participating state agency.

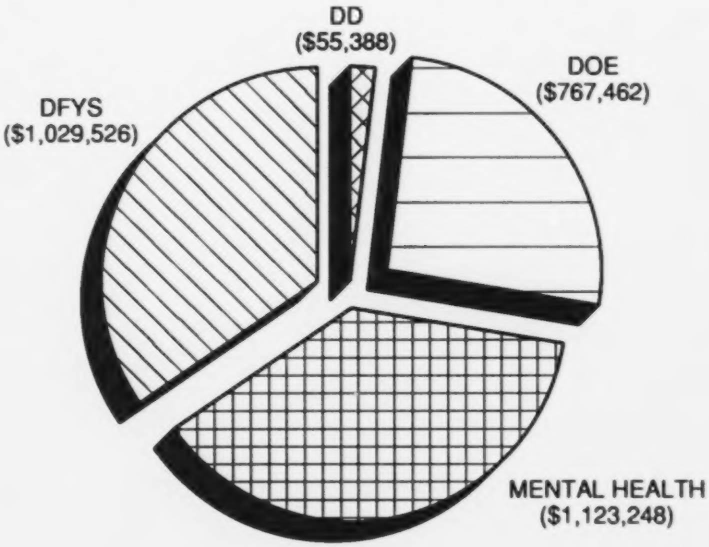


FIGURE 6
Multiple-Agency AYI Funding Pattern, by Proportion of Total Caseload

This figure illustrates that the funding for individual AYI youth is often shared by the participating agencies . . . interagency collaboration in action!

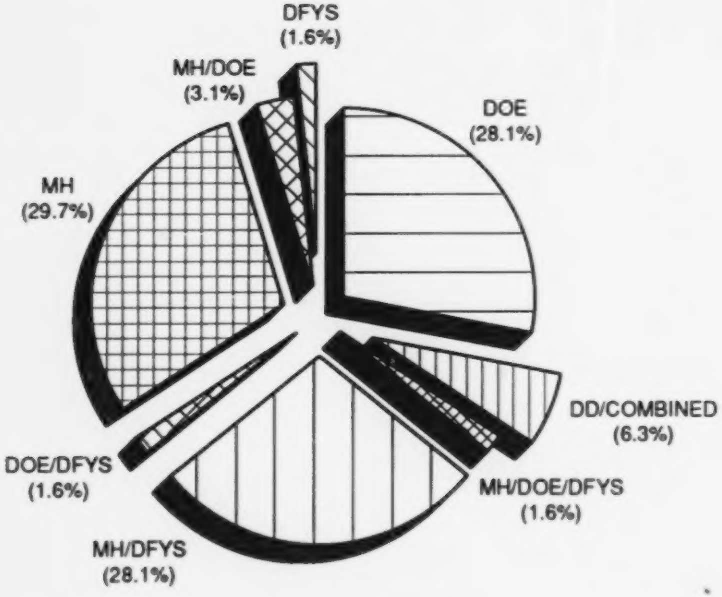
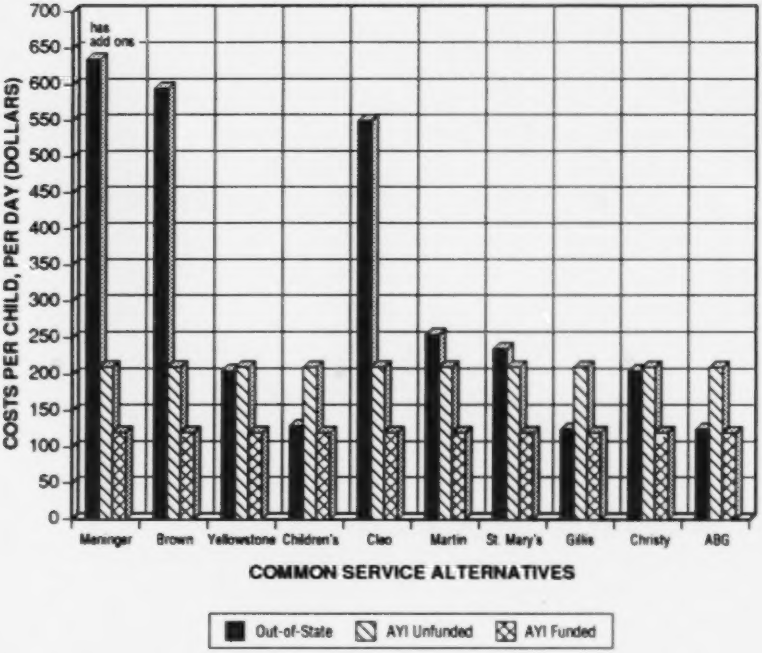


FIGURE 7
Non-Alaskan Facility Cost Comparisons: Out-of-State versus AYI

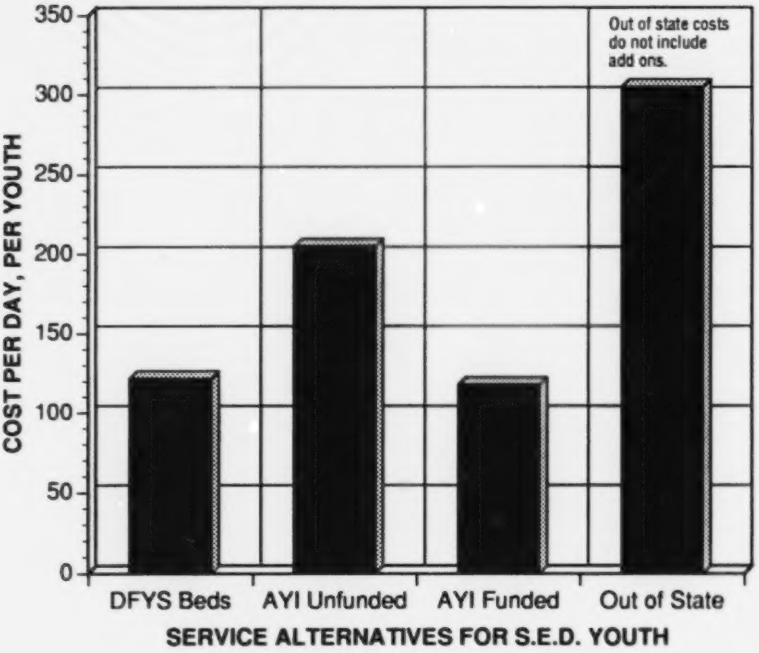
This figure shows the actual verified per-day costs of 10 out-of-state institutions compared to AYI projected first-year costs for the unfunded youth and actual average cost over time of AYI-funded youth.



Out-of-state costs do not include add ons.

FIGURE 8
Out-of-State Costs Compared to DFYS and AYI In-State Costs, All Costs Averaged

This figure shows the cost of AYI interventions compared to the average cost of a DFYS funded residential bed, and to the average daily cost of five commonly used out-of-state facilities. The projected first-year cost of the "AYI unfunded" group is higher than the actual average cost over time of the "AYI funded" group because AYI youth tend to cost more their first year and then rapidly decrease in cost as the youth improves. Out-of-state costs only rise over time, and do not reflect add-on costs, such as education and medical costs (often adding $100 or more to the daily cost).



AYI Successes

The following are examples of AYI successes. To maintain confidentiality, names, locations, and minor details have been changed.

> **Keith,** age 10, came into AYI 2 years ago. He was abandoned by his parents at age 2, and had 13 failed foster homes. He attacked his teachers at school on numerous occasions and physically destroyed a classroom. He was referred to a locked psychiatric hospital in Oregon, but was diverted into AYI instead. During the first 6 months of his program, Keith showed many challenging and disturbed behaviors. Now, because of the success of an intensive individualized plan and a determined team that did not give up on him, Keith has lived with the same specialized foster parent for 2 years, is doing well in school, and is vibrant, happy, and has great potential. The cost of his care has been 37% of the cost of out-of-state placement.
>
> **Suzy,** age 18, has been transitioned out of AYI for over 6 months. She came into custody at age 4. Failing in school as a special education student, she came into AYI at age 15 with a long history of assault, suicide attempts, runaways, and drug use. She had failed in all placements with family and foster parents, and frequently falsely accused caregivers of sexual abuse. Led by local AYI staff, school, mental health center, and DFYS staff, an interagency team designed and jointly implemented a specialized "shared care" arrangement in the community, which prepared her to later live in specialized foster care. She is now in school full time, has been drug free for over 2 years, is living with a caring family member, and is planning on entering college after she graduates from high school.
>
> **Gerald,** age 18, came into AYI at age 16 after spending 3 years in a locked psychiatric hospital in Texas, at a total cost to the Department of Education of over $300,000. He was from a small village in southeast Alaska. In his first week back from out-of-state care, he assaulted a neighbor and stole from the local church. Through AYI and a highly individualized plan including a team, a work program, and intensive family support, he has recently graduated from high school and is working part-time as a laborer, and is a contributing member of his village.
>
> **Debbie,** age 18, suffers from schizophrenia. Four years ago, after frequent and disabling psychotic breaks, she was not able to attend school, was increasingly unstable, and her parents were at risk of divorce due to the stress. Her psychiatrist felt that she might have to be institutionalized in Seattle. Through an individualized AYI plan, the psychiatrist, the community mental health center's AYI staff, and the local special education staff worked to educate Debbie's friends and family in the subtleties of mental illness. Debbie had a flexible school

plan that could change from a school-based program to a home-based program when she had active mental illness. Her parents received respite care and other support services. Debbie has now gone over 2 years without a psychotic break, did well in high school, is gradually increasing her class hours at the local college, and her family is stable.

Connie, age 17, with a long history of violence and suicide attempts, was in a locked psychiatric hospital in Tennessee for 2 years, at a cost to DFYS of over $150,000 per year. She started using drugs and became pregnant when she ran away from the hospital. After her hospital discharged her due to pregnancy, she was returned to Alaska with an armed guard. The out-of-state institution recommended her return to the institution after she gave birth, and felt that she could not parent her child or be served in the community. Using AYI as back-up, a team consisting of the local social worker, a guardian ad litem, local AYI staff, and her grandmother designed a flexible plan to phase her slowly back into her community. She eventually obtained her GED and is successfully parenting her baby, who has not had to be placed in state custody.

Youth Who Have Not Benefited

As the information in Figure 1 indicates, there have been youth who have not benefited from the program. Approximately half of these youth fit a clear profile: They entered the program at age 17 or older; they had the legal right to refuse further involvement in the program; and they exercised this right and withdrew from the program even when the services teams continued to offer unconditional care. Several of these youths have voluntarily returned to AYI (some of them many times), and some of them have eventually "made it" in the program. Others have never returned to the program.

Over 75% of the youth who have not benefited from the program have been conduct disordered youth who have had extensive involvement with juvenile justice (Youth Services) during the time that they were in AYI. Over 30% of the youth who were rated as having "poor outcomes" have since improved and appear to be benefiting from individualized services.

All youth are not succeeding in the program. For example, a youth may have committed a crime while in AYI and have been locked up in McLaughlin Youth Center. This youth is considered to be still in AYI, and services will continue when he is considered ready to be released. For some youth, *brief* institutional placement is a very effective juvenile justice or mental health treatment alternative. The important factor is that AYI does not give up on these youth nor does AYI consider them to be failures.

Another factor affecting youth who are not benefiting from AYI services involves the integrity of the individualized interventions offered to the youth. As with any model of services, great care must be taken to monitor the "doing" of the interventions. External program review has indicated that the AYI providers sometimes do not follow the basic "must-dos" of individualized services. AYI now recognizes the need to perform better and more frequent training about the "how to" part of individualized services, and the need to monitor the performance of providers on a more frequent basis. The job duties of state-level AYI staff are being rewritten to ensure that this training and monitoring is done.

Recent Improvements

During the last year, the AYI program has undergone some major changes. Some of these were in part generated by obtaining feedback from parents of AYI youth, advocates, providers, and other interested parties. In addition, AYI was the object of a major external review by a national expert in the delivery of individualized services, Dr. John Burchard, of the University of Vermont. Dr. Burchard was the Commissioner of Health and Social Services for Vermont for over 5 years. His review and previous reviews reported, among other things, that AYI needed to improve training of staff and providers, develop better budgeting procedures, and develop policies and procedures that would provide better liability protection.

AYI has now finalized and is testing foster parent training packages; has dramatically improved fiscal management and budgeting procedures and has produced a draft policy and procedures manual; has developed and implemented a training package for all new staff and providers; has revamped all filing and documentation procedures; has developed a database on all AYI children; and has produced draft regulations on AYI.

Improvements Needed or in Progress

1. The IDT feels strongly that the present system in which each participating state agency keeps its own AYI budget and then blends the funding, is an inefficient system. A better, more cost-effective alternative would be to create one AYI fund that the agencies would then manage jointly.
2. The IDT feels that staff from the Division of Alcohol and Drug Abuse, the Division of Medical Assistance, Developmental Disabilities, and from Youth Services should be added to the IDT.
3. AYI is working to improve its methods of tracking and measuring services outcomes, through participation in a multistate effort led by the Center for Research and Public Policy in Pennsylvania.

4. AYI is working to develop better policies for how and when youth are discharged, and to recruit more agencies to be AYI providers. In addition, better methods of recruiting and maintaining specialized foster parents need to be developed.

AYI Management

The Alaska Youth Initiative is managed by the Interdepartmental Team (IDT). The current IDT is:

Carolyn Frichette, MA, Residential Services Coordinator, Alaska Division of Family and Youth Services

Richard Smiley, PhD, Consultant, ED Programs, Alaska Department of Education

John VanDenBerg, MA, Coordinator, Child and Adolescent Mental Health Services

AYI Literature

The following AYI-related documents may be obtained by writing:

Alaska Division of Mental Health and Developmental Disabilities
Attention: John VanDenBerg or Robert Sewell, PhD
Box H-04
Juneau, AK 99811-0620

PLEASE NOTE: WITH THE EXCEPTION OF REQUIRED STATUS REPORTS AND TRAINING MATERIALS, ALL PROFESSIONAL WRITING BY AYI STAFF HAS BEEN ACCOMPLISHED OUTSIDE OF WORK HOURS, DURING THE PRIVATE TIME OF AYI STAFF.

Born, David G., VanDenBerg, John, & Risley, Todd R. (1988). *The Alaska System of Statewide Monitoring of Client Outcome Data.* Juneau: Alaska Department of Health and Social Services. (19 pp.)

Sewell, Robert. (December, 1990). *Answers from AYI: A Series of Summary Statements Regarding Selected Features of AYI.* Juneau: Alaska Department of Health and Social Services.

VanDenBerg, John. (1987). *Initial Demonstration Project Outcomes.* Alaska Division of Mental Health and Developmental Disabilities. (12 pp.)

VanDenBerg, John. (1989). *The Alaska Youth Initiative Program Background.* (37pp.)

VanDenBerg, John. (December, 1990). *State and National Recognitions: The Alaska Youth Initiative.* Juneau: Alaska Department of Health and Social Services. (7 pp.)

VanDenBerg, John, Rummel, Jacqueline, Brimner, Karl, & Sewell, Robert. *Status Report: The Alaska Youth Initiative.* (March, 1989). Juneau: Alaska Department of Health and Social Services. (20 pp.)

Books or Book Chapters

Several books or book chapters about AYI are currently underway, in various stages of completion:

1. **Georgetown University** is publishing a book on AYI that focuses on case studies of ten selected AYI youth. This has been tentatively titled *One Kid at a Time—The Alaska Youth Initiative: A Demonstration of Individualized Services*. The authors are J. Burchard, S. Burchard, R. Sewell, and J. VanDenBerg.
2. **Yale University School of Medicine** is publishing a book titled *How to Help Children and Adolescents Who Have a Biologically-Based Brain Disease—and Their Caring Families*. The book will include a chapter on the value of individualized services in treating youth who suffer from serious mental illness. The author of this chapter is J. VanDenBerg.
3. **The National Institute of Mental Health** is publishing a monograph on three model programs that serve youth with severe emotional disturbances. This will be part of their *Series on Community Services* volumes that are published through the CASSP Technical Assistance Center. The author of the document is J. Katz-Leavy.
4. AYI staff on a local and state level are compiling an edited book on individualized services (J. VanDenBerg and T. Risley, Eds.) that is presently untitled.
5. Two articles on AYI are soon to be published. The first, titled "The Value of Building Individualized Services Into a Standard System of Care," will be published in the Fall, 1991 issue of *Administration and Policy in Mental Health*. The other article, written for parents of children with a mental illness, will be published in the fall newsletter of the National Alliance for the Mentally Ill Child and Adolescent Network. The author of both articles is J. VanDenBerg.

This document was prepared by John VanDenBerg, Coordinator of Child and Adolescent Mental Health Services, DMHDD; Robert Sewell, PhD, Coordinator of Individualized Services to Children, DMHDD; and Karen Kubley, Individualized Services Fiscal Specialist, DMHDD.

Please write or call if more information is needed.

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES
DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES
BOX H-04, JUNEAU, ALASKA 99811

(907) 465-2195

Special Recognitions

AYI is the work of literally hundreds of Alaskans. At the present time, there are over 125 persons who have jobs caring for the AYI youth with the same funds that we used to hire persons in other states. However, several groups of people need special mention as being key to the development of AYI:

First, credit must go to all of the persons who work directly with the youth, including the parents and families. These people, and the youth themselves, are the real heroes of AYI.

Next, thanks to all the policymakers who have made key decisions that have resulted in our successfully keeping our youth here in Alaska where they belong.

Finally, thanks to all of the support personnel within the DOE and the DHSS who work behind the scenes—helping push budget revisions through, managing personnel issues, ordering supplies and paying bills, and all of the other critical tasks needed to make an effort work.

Appendix F

Bluegrass IMPACT Accomplishments to Date

Section 2.A. Summary of Progress on Development Year Objectives and Work Plan Tasks

The development of a comprehensive system of care for children with severe emotional problems has been an exciting challenge for the child-serving agencies in Kentucky. The complex service needs of the children and their families have been further clarified through the Kentucky Robert Wood Johnson Foundation Initiative, now known as Bluegrass IMPACT—Interagency Mobilization for Progress in Adolescent and Children's Treatment. The need for multiagency collaboration and funding has been fortified in the development of structures to recognize and respond to these needs.

Three goals were identified early in the process of the development of this system of care. These goals and a summary of the progress that has been made toward their achievement are listed below:

Goal 1: Organization—Improve interagency coordination of public and private services on behalf of children and youth with severe emotional problems and their family members.

Summary of Progress

- On October 19, 1989, a Robert Wood Johnson Foundation Forum for Children and Youth with Severe Emotional Problems was held in Lexington, Kentucky. Gathered together were 150 representatives of state, regional, and local child-serving agencies and parents' groups to learn from national experts about the possibilities that exist for children and their families when services are comprehensive and coordinated and to share their priorities for a system of care in Kentucky. The objectives developed by these people and their continued efforts have driven the development process and have led to the current implementation strategies.

- Governor Wallace G. Wilkinson signed Executive Order #89–1044 on November 6, 1989, officially establishing the State Interagency Council for Children and Youth with Severe Emotional Problems (SIAC). This order enables the SIAC to establish regional councils (RIACs) and to take action on children's issues regarding the coordination, delivery, and financing of services. Participants on the SIAC include the deputy secretary to the governor, the secretary for the Cabinet for Human Resources, and the commissioners and directors of the state's child-serving agencies.
- The state interagency coordinator, the regional interagency coordinator, and two support staff were hired in September and October.
- The State and Regional Councils (SIAC and RIAC) have met on three occasions to provide direction and to implement recommendations affecting the services to the targeted children.
- Seven regional committees have worked tirelessly to address organizational, financial, and service delivery issues. The content areas of case management, community services, data management, education, placement review, and residential services have been explored. Recommendations from these committees have been made to the RIAC and SIAC for approval. Each of these committees have multiagency and multidisciplinary representation.
- Written interagency agreements have been drafted and negotiated with the community mental health centers, social services, the district courts, the school districts, providers of residential and hospital services, and health department representatives to coordinate the caregiving system on behalf of children with severe emotional problems who have been determined to be in greatest need. Many of the agreements have been signed and became effective on August 1, 1990. The benefits of this collaborative effort have already been felt.
- Policies and procedures for the operation of SIAC and the Bluegrass IMPACT Regional Council have been drafted and approval is pending.

Goal 2: Finance—Ensure financing for a comprehensive system of care through creative interagency collaboration and public-private partnerships.

Summary of Progress

- A SIAC finance committee has met separately to address the funding, billing, and tracking needs of the project.

- A secure match has been determined with the use of new and reallocated funds from the Departments of Mental Health ($100,000), Social Services ($120,000), Medicaid Services (estimated $222,000) and Education ($100,000). Local government funds have been requested to support several staff positions in the pilot area ($48,000).
- Using Bluegrass IMPACT as a model, a statewide system of care for children with severe emotional problems was developed and been presented to the 1990 Kentucky legislature for possible funding. This plan was a cooperative effort of the Departments of Mental Health and Mental Retardation Services, Special Services, and Medicaid Services and called for a fourfold increase in the amount of state general fund money to be spent on community-based services for this population. Full funding of this plan was a top priority of all three departments, the Cabinet for Human Resources, and several key legislators.
- The Department of Medicaid Services has agreed to revise its criteria, in cooperation with the Departments of Mental Health and Mental Retardation Services and Social Services, whereby children are certified for admission to psychiatric hospitals or residential treatment facilities. These revisions will focus on the reduction of the number of children placed in these settings inappropriately. This will be accomplished through (1) the development of more definitive criteria, (2) the use of a review body that has specialized expertise in child psychiatric care, and (3) the use of regional interagency teams for consultation regarding the availability of community-based alternatives.
- An expansion of the options covered by the Kentucky Department of Medicaid Services has been included in the governor's budget. The options are targeted case management for severely emotionally disturbed children, intensive in-home services, and small (16 beds or fewer), community-based, residential treatment facilities. Also included in the governor's budget is language that commits the Department of Medicaid Services to redirect the anticipated savings generated through cost avoidance in child psychiatric hospital services to fund additional, community-based, mental health services.
- The SIAC has approved the preliminary financial plan for the implementation phase of the Bluegrass IMPACT project. Long-term strategies are being discussed.
- The Child Adolescent Service System Program (CASSP) has committed $3,000 to the operations' budget of the project.
- Local businesses and organizations are committing to the on-going provision of goods, services, and financial support through the community services committee. Efforts have begun to solicit long-term financial support from major corporations and organizations in the Bluegrass region.

Goal 3: Service Delivery—Develop a full continuum of community- and family-based resources in the Bluegrass region as a successful demonstration of the system of care that could be replicated in other regions of the state and nation.

Summary of Progress

- A nominating and selection process has been developed, tested, and revised to determine client characteristics, service needs, and potential outcomes.
- Job descriptions and organizational tables have been designed for effective service delivery.
- A pilot project, using existing resources, is currently testing the design and effectiveness of the service delivery system for both client and family.
- The *Manual for Intensive Service Coordination* has been written to provide service protocols and mechanisms for quality assurance.
- A data tracking plan has been developed that will facilitate interagency communication and support. Long-term evaluative measures have been determined.
- The array of services has been determined based on the indicated needs of the nominated children. Service models are being identified and replicability is being determined.

The development of the system of care is on its original schedule. Other components have been identified and completed as noted above. One major addition to the work plan is the recruitment, hiring, and training of staff for the implementation phase. Although some staff positions are vacant, sufficient staff have been hired to make all programs and services operational.

Section 2.B. Review of Selective Program Elements

Section 2.B.1. Target Population Ready to Serve

The number of youths to be served from the target population in the first 4 years of implementation is 1,056. In a sample of 200 taken from the nomination process, the following characteristics were found. We believe these characteristics are representative of the target population.

Of the 200 children sampled, 78% were male. Caucasian children make up 63% of the sample, while 11% are Black. Black youths were slightly over represented in the urban county. The remaining 26% specified no race. Ages range from 3 to 19 with 52% between the ages of 10 and 14. The average age of referred youth was 12.

In terms of current living arrangements, 25% of the sample live in a single-parent household, while 29% live in a two-parent household. Twelve percent are placed in foster homes, while 16% are currently placed in residential settings. The remainder are in other out-of-home placements. There were 315 known prior out-of-home placements among the 200 nominated children.

Most of the children are involved with several agencies at the present time. The average referral is involved in four agencies at this time. These agencies typically are schools, social services, the courts, and community mental health centers. Multiple agency involvement is typically a characteristic of nominated children. The number of agencies involved with a child is less in rural counties because there are fewer resources.

The three most common psychiatric diagnoses in the sample are conduct disorders (13%), oppositional defiant disorders (11%), and attention deficit disorder (10%). A notable characteristic about the diagnoses in the sample is that at least 18% of the children have dual or multiple diagnoses.

A detailed follow-up of Medicaid eligibility was completed on the nominations in the most populous county. It was found that 61% were eligible for Medicaid. This suggests a major overrepresentation of children in state custody or in poor families among the referrals. For the total population of the children residing in the county, only 9% are Medicaid eligible.

The nomination process sought to address Kentucky's desire to ensure that the target population was representative of the entire region and identified children whose needs were most severe. Cover letters explaining Bluegrass IMPACT were sent to the heads of all local child-serving agencies in the 17 counties of the Bluegrass region asking them to nominate their five most severely affected children in accordance with the project's definition of a child with severe emotional problems. This definition includes components related to diagnosis, level of disability, duration of required services, and multiagency need. These letters were signed by the state or regional leader who had the most direct relationship with that agency. The list of agencies that received the nomination forms included community mental health centers, social services systems, school systems, health departments, residential child care centers, the region's only psychiatric hospital, and courts. Although nomination forms were not sent directly to parent groups, these individuals are being made aware of the process to ensure that they receive appropriate consideration.

The process intentionally produced an overrepresentation of children in the rural counties. The urban county does have the greatest number of children, and the greatest number of resources. Unmet needs are therefore more prominent in the rural areas. The nomination form data, which have been tested and revised during the developmental year, yield numerical problem and critical problem scores, as well as additional information that can be used in assessing the seriousness of the child's problems. The assessment tool used in the North Carolina Pioneer Project will be used as a parallel instrument during the first year of the project.

Final acceptance of nominated children will be made by the Local Admissions and Review Committee (LARC). This is an interagency committee staffed by the local resource coordinator (LRC) and chaired by a representative of an agency other than the community mental health center.

In addition to assuring that nominated children meet the definition of a child with severe emotional problems, the LARC will evaluate the child's situation and give priority to the following:

1. Children currently in a hospital or residential placement,
2. Children who are at risk of placement into a more restrictive residential or treatment setting, and
3. Children who have a history of multiple, out-of-home placements.

In identifying these populations as a priority for services under this grant, Kentucky will focus on the following:

1. Reducing the restrictiveness of residence or treatment as appropriate, and
2. Avoiding the costs associated with hospital and residential care.

By involving all the key agencies in the identification and service delivery process, Kentucky will focus on improving a child's access to services within the community and ensuring the coordination of those services.

While the LARC will make its selections on the criteria identified above, it will also be in a position to make exceptions as deemed necessary. The actions of the LARC shall be subject to appeal to the Regional Interagency Council.

Documentation for both the financial and service components will be completed by the service coordinators (case managers) and forwarded to the Bluegrass Mental Health/Mental Retardation Board. The board has an effective documentation and billing system that has been in place for 5 years. The client data and billing systems are integrated and include areas for assessment and treatment planning.

Clients will be identified by social security numbers across all documentation. Each service provider will complete a service ticket following any billable interaction with the client, family, or other members of the support system. Service tickets are submitted to the administrative offices on a daily basis. The board's in-house computer program is able to detail the type of service, date, length, provider, location, payor, and cost of service by client; tracking can also be done by service. This information will provide IMPACT staff with an overview of monthly services provided for the client and the project.

Section 2.B.2. Program Design

At the core of the Bluegrass IMPACT program is service coordination through an intensive case management system. Surrounding that core is an interagency network of services.

On the administrative levels, there will be a State Interagency Council (SIAC) and a Regional Interagency Council (RIAC). The participation of key agency administrators at these levels will provide state and regional sanctions for the interagency project and provide an interagency forum for policy development and problem solution. These bodies have functioned well during the planning phase and are oriented and ready to continue as soon as implementation funds are committed.

At the level of the three mental health catchment areas in the Bluegrass region, the Bluegrass IMPACT program will be organized into similar structures. There will be a LARC in each catchment area with representatives from the Department of Social Services, the community mental health center, the schools, the courts, and consumer groups (at least one member of a parent organization). When possible, representatives of the local health department and private child care agencies will be included on the LARC. This group will make admissions decisions, review services, and facilitate local cooperation. The local resource coordinator will serve as staff to the LARC and will supervise the service coordination efforts within the catchment area. The LARC will also participate in the annual personnel evaluation of the local resource coordinator.

The local resource coordinator will supervise the service coordinators within the catchment area, assign cases, and monitor progress. The local resource coordinator will also be responsible for the assignment of children to the Bluegrass IMPACT staff in each catchment area. This staff includes the flexible response, in-home, and school support staff. The clinical and administrative supervision of these staff will vary with the structures of the different catchment areas.

The proposed organizational structure will allow most of the new services to be coordinated within the community mental health center, while providing interagency control over acceptance, treatment planning, case review, and the assignment of resources. These procedures will produce a well-coordinated service delivery system with a high degree of interagency collaboration. The selection of the community mental health center as the primary agency to hire, supervise, and ensure the coordination of the new services developed in response to the Bluegrass IMPACT program was based on the following factors:

1. The community mental health center is, by Kentucky statute, the regional planning authority for mental health services;
2. The clinical staff of the community mental health center can provide technical assistance and consultation to program staff to ensure the quality of mental health assessments and services; and
3. Outpatient mental health services for Medicaid reimbursement are exclusively provided by the community mental health centers.

All referrals to the Bluegrass IMPACT program will be made to the local resource coordinator at the community mental health center. The local resource coordinator will make a preliminary assessment of the referral and begin the assessment process as described in the Bluegrass IMPACT program *Manual for Intensive Service Coordination*.

On the day that each referral is received, it will be entered into the computer tracking system. This system will have files for intake data, assessment data, plans, and transactions. A current master file will link the files and allow for tracking the development and progress of the child's plan. There will be procedures for automatic notification of parents and assigned agency staff at regular intervals and when deadlines, changes, or problems occur.

The computerized tracking system will be managed by the service coordinators within the community mental health system. There will be several external checks on the tracking system itself. Families and agency workers who are involved in plans and deadlines will be aware of problems if the tracking system fails to do its job; the LARC will make periodic review of the service coordination system to monitor progress; and summary reports will be produced by the state interagency coordinator for presentation to the SIAC.

For each child, there will be a Child's Interagency Planning and Implementation Team (CIPIT). The members of this team will be those agency workers with primary responsibility for the child. For the major agencies involved, participation in the CIPIT will be mandated by interagency agreements. For all agencies, private practitioners, or volunteers, the service coordinator should enlist cooperation based on a strong purposeful plan and the value of cooperating for the benefit of the child served.

Within the community mental health center, the addition of a service coordination unit should sensitize therapists to case management issues. Service collaboration will be implemented through the LARC and the CIPIT. These teams will follow a protocol for common planning. Staff will be devoted to oversight, follow-up, and advocacy for the families involved.

The role of existing services such as day treatment, afterschool programs, summer programming, in-home service, therapeutic foster care, and residential services will be viewed as part of an integrated continuum of care that gives priority to children with severe emotional problems. Some services will respond to children who would have been rejected as too troubled in the past. The project will offer flexible response or backup staff to assist other agency staff in the children's care.

New services under this grant include intensive service coordination assisted by flexible staff (flexible response team members) and dollars (wraparound funds). In-home services will be increased. School support staff will assist school personnel with IMPACT children, particularly in more rural counties where there has been a pattern of weaker services and underidentification. Therapeutic foster care will be introduced in year 1 to fill a gap in the service spectrum. Although not grant-funded, the following related services have been or will be developed because of interest generated by the Robert Wood Johnson Foundation proposal:

1. The addition of more services to children with severe emotional problems to the schools in the region, targeted particularly at Bluegrass IMPACT children
2. An increase in after-school programs
3. Transitional living programs sponsored by two private child care agencies, and
4. The development of a 12-bed group home in or near Fayette County for juvenile offenders.

Section 2.B.3. Clinical Program

Assurance of quality care is provided. Included in this are:

1. Interagency child-centered treatment planning
2. Intensive case management
3. Strong clinical support and supervision, and
4. A utilization and review process that provides for medical records and peer review.

Treatment planning will originate in the CIPIT and be based on a thorough interagency assessment. The mental health treatment plan will be reviewed by the community mental health center's child psychiatrist. The total plan will be subject to periodic review by participating agencies, the child's parents and, if appropriate, the child.

Intensive case management will be the responsibility of the service coordinator, who will monitor the child's treatment and initiate changes as needed, with major revisions going back to the CIPIT for review and future direction. Every 6 months, the service coordinator will complete a review of clinical and cost avoidance outcome variables.

Strong clinical support and supervision are the third assurance of quality care. The three children's coordinators are experienced psychologists highly regarded for their clinical skills and have excellent working relationships with community resources. There are child psychiatrists in each catchment area. The psychiatric staffing serves as a medical review where decisions are made regarding laboratory tests, EEGs, or specialized medical evaluations.

Finally, the community mental health center has a formal system of utilization and review of all client records that includes peer review for clinical appropriateness and quality of services.

Section 2.B.4. Model for System Accountability

Accountability for services delivered through the Bluegrass IMPACT will be maintained—through a comprehensive evaluation system that captures data on clinical effectiveness, cost efficiency, and system effectiveness. Individual reviews assessing progress in each of these measures will be conducted at 6-month intervals. Summary reports will be prepared on a quarterly basis; a complete project review will be conducted annually.

Clinical outcome variables will evaluate the multiple facets of a child's life, including self, home, school, and community. At intake and every 6 months thereafter, the client's behavior will evaluated by the service coordinator (using statistical information, such as days out of school), the parent (using the Achenbach Child Behavior Checklist), the teacher (using the Conners Teacher Rating Scale), and the child (using the Piers-Harris Self-Concept Scale). In addition, the parent's mental health will be evaluated by a parent self-report using the Center for Epidemiologic Studies Scale of Depression (CES-D). Multivariate statistical analysis should demonstrate an improvement in each area from intake through the child's participation in the project. The clinical outcomes will measure specific indicators including information on school attendance, juvenile detention, assaultive behavior, property damage, alcohol and drug use and/or possession, plus critical outcomes such as suicide attempt, school suspension, or failed placement.

Cost avoidance variables monitor those client behaviors that reflect project goals and have direct impact on the financial cost of residential placement and inpatient hospitalization of children with severe emotional problems. Overall benefits of the project will increase from year one to year four, and benefits to individual children will be maintained over the term of the project.

System outcome variables will be defined by the work plan and monitored by the coordinator of the State Interagency Council. Detailed progress toward the achievement of these outcomes will be reported to the SIAC on a quarterly basis.

The clinical outcome and cost avoidance data will be collected by the service coordinator during the initial assessment phase and every 6 months thereafter. Major changes, for example, the return of a child to the community or the hospitalization of a child, will be recorded in the computer database on an ongoing basis. Six-month reviews will be prompted by the computer notifying the service coordinator and providing mailing labels. The computer database will also provide monthly summary statistics on progress in meeting the above goals which will assist with administrative decision making by the local, regional, and state interagency councils.

Section 2.B.5 Refinement of Financing Strategies

Kentucky's financing strategies of its initial grant application have been further developed and expanded during the planning year. The revised strategy addresses many different sources of funding, but concentrates on securing new state funding and on expanding Medicaid participation in the funding of newly developed services. A more detailed summary of this six-point strategy appears in Section 3.B. Strategy for Continuation Funding.

Much has been accomplished in the past year to secure resources. A major effort has been the joint development by the Department for Mental Health and Mental Retardation Services, the Department for Social Services, and the Department for Medicaid Services of the Cabinet for Human Resources' *Plan to Address the Mental Health Needs of Kentucky's Children and Youth with Severe Emotional Problems* (1989). This plan is based on major features of the Bluegrass IMPACT proposal. If funded, it would establish a statewide system of care containing at least one unit of 10 core services in every region of the commonwealth. The plan calls for \$11.5 million in state and federal (Medicaid) funds in fiscal year '91 and \$21.5 million in fiscal year '92. In the Bluegrass region, the plan calls for approximately \$2 million in new DMHMRS and Medicaid funds by fiscal year '92 plus \$920,000 for a small, community-oriented, residential treatment facility by fiscal year '94 or earlier. The governor's budget contains funds for parts of the plan, and the General Assembly is currently considering the governor's budget as well as the needs outlined in the full plan. A 2-year state budget has been approved by the Legislature.

The Department of Medicaid Services has been a full partner in the effort to improve the level of community-based mental health services. The community mental health centers have increased their use of present Medicaid options; and data on Medicaid utilization by the demonstration projects has helped us refine the estimates used in the Bluegrass IMPACT budget. Medicaid is now committed to a gate keeping procedure regarding admissions to psychiatric hospitals or residential treatment facilities including consultation with the RIAC concerning available community options. Additionally, the governor's budget has been amended to include language related to the diversion of funds from anticipated cost savings in the hospital sector to the costs associated with expanded community-based services. The Department for Medicaid Services participated in the development of this language and is committed to the redirection of funds. A committee including DMHMRS, DSS, DMS, and the Division of Licensing and Regulation is currently working to strengthen the criteria.

In summary, the Bluegrass IMPACT initiative has facilitated progress in the following three areas:

1. Improved use of existing Medicaid options;
2. Agreements to strengthen the admission criteria and seek consultation from the RIAC regarding less restrictive alternatives; and
3. An agreement to redirect savings generated through a reduction in the use of hospital care to community-based services.

In addition, the governor's budget calls for an expansion of the optional services covered by the Medicaid program. These expansions include targeted case management, intensive in-home services as a separate service, and small (16 beds or fewer), community-based psychiatric treatment facilities.

The Department for Social Services and Education has also demonstrated its commitment to Bluegrass IMPACT and to the expansion of services for this population through a reallocation of funds to ensure a substantial match and an effective array of services.

Other progress on financing strategies includes the development of a staffing grant which we expect to be funded by the Lexington/Fayette urban county government, and donated time by community mental health center and DMH staff. DSS has committed one of its staff to be a Service Coordinator. The community services committee of the RIAC has organized itself to seek donations and grants, and a subcommittee is prepared to actively seek participation in the project by private insurance, HMOs and EAPs. The governor's office has been a full participant on the SIAC and has been named in the executive order.

Revised Implementation Plans

Section 3.A. Development Strategy

The continued development of Bluegrass IMPACT will follow the goals and strategies identified and refined throughout the planning year. The original goals have served as the focus of this project and will move Kentucky toward a comprehensive service delivery system developed for children with severe emotional problems.

The organization as described in the program design will be initiated during the first 2 years of implementation. The direct service staff will begin to be recruited, hired, and trained during the opening months of year l. The local resource coordinators and approximately one-half of the local staff will begin direct services during the first quarter. As case loads build throughout the year, additional staff will be hired. It is estimated that 220 children will be served during the first year; approximately 280 additional children will be served in each of years 2 through 4. Additional staff and service components will be added in each year of the grant.

As the service delivery system is realized, interagency collaboration will increase. Committees established on the regional level during the planning year will continue interagency integration of services to these children. The community services committee will direct efforts to increase the commitment of local businesses, corporations, and agencies to this population. Community resources including services, financial support, volunteers, and respite opportunities for families will be established. The education committee will continue the integrated services strategy undertaken during the planning year. The placement review committee will implement the findings and recommendations for least restrictive care developed during the planning year. As an integral part of the system of care, mental health and health professionals will assist in the determination of the need for residential placements. The residential committee will be instrumental in the development of components to the service array in years 1 and 2 of the grant including therapeutic foster care and residential support service.

Over 65 agencies are represented on the 5 active regional committees and the regional council. Recommendations for the interagency implementation of various components will be presented to the Bluegrass IMPACT Regional Interagency Council (RIAC) for discussion and approval. The RIAC is comprised of 15 child-serving agency administrators who determine policy and procedures for the service delivery system. Meeting monthly, this decision-making body will also serve as the final case review authority for the project. Reporting to the RIAC will be the local resource coordinators who will oversee the service coordination for each catchment area.

The State Interagency Council for Children and Youth with Severe Emotional Problems (SIAC) determines the policy and procedures for itself and the RIAC. The SIAC will respond to recommendations from the RIAC. As the statewide system of care is implemented, this body will act as the authority for other regional councils. Other interagency issues, such as facilitating the coordinated transition of the child into adult services and negotiating blended funding, will be addressed on the state level.

The director of the Division of Mental Health will serve as the project director and will oversee all aspects of the grant. Project management decisions will be made by the project director, with the approval of the SIAC and with significant input from the state coordinator. Management authority will be appropriately delegated to regional and local staff.

Section 3.B. Strategy for Continuation Financing

Kentucky's plans for securing matching funds include these seven strategies:

1. *Medicaid funding.* Based on current nominations, over 50% of Bluegrass IMPACT children are expected to be Medicaid eligible. Kentucky's Title XIX program already has progressive coverage of mental health services under the rehabilitation option. Planned expansions by fiscal year '92 include targeted case management, intensive in-home services, and JCAHO-accredited residential treatment facilities. With existing and planned coverage, Medicaid can provide a significant portion of the funding for most of the new and expanded services in this proposal. In addition, DMHMRS and DMS will continue to jointly explore the feasibility of home, community-based and capitation waivers and of making more strategic use of EPSDT. These latter strategies would expand eligibility and provide increased flexibility in service options. Although they require much more study and planning, the potential for testing at least one of them in years 3 and 4 of the grant in the limited geographic area of the Bluegrass is very attractive.
2. *Other grants.* We expect to receive a matching grant through the Lexington/Fayette urban county government for $48,472 to $73,472, which would provide for two service coordinators and possibly 1.0 FTE clinician at the community mental health center to focus on Bluegrass IMPACT children. We are seeking small matching grants from other foundations. The community services committee is committed to fundraising with large corporations and organizations in the Lexington area. In addition, a plan is in place

for soliciting and utilizing donated goods and services as part of a resource pool for Bluegrass IMPACT children and their families.

3. *Participation of schools.* The Department of Education has committed $40,000 per year to help finance the school support specialists. We also expect in-kind contributions and joint program development from local schools. By years 3 and 4, we expect school support specialists to be substantially funded with state and federal funds. Initial discussions between the Department of Education and Department for Medicaid Services have focused on schools becoming eligible Medicaid vendors for some services. The school support specialists would become a model for testing many particulars of such an agreement.
4. *Private insurance.* A gradual increase in participation of private insurance, HMOs, and EAPs is projected over the length of the grant. A community services subcommittee has responsibility for investigating this area and for actively seeking provider participation. A very small but increasing amount of self-pay funds is also projected.
5. *Reallocated state funds through the Departments of Mental Health and Mental Retardation Services and Social Services.* Because of the Department for Social Services' commitment to this initiative, the commissioner of the Department for Social Services has agreed to reallocate $100,000 per year for wraparound services to Bluegrass IMPACT children. Likewise, the Department for Mental Health and Mental Retardation Services has agreed to reallocate $75,000 per year for wraparound services, consultant honoraria, and consultation training for staff. Other possible sources of reallocated state funds include some children's special project funds through the DMHMRS which have been freed up by greater utilization of Medicaid, DSS funds which may be freed up in later years through new Medicaid options (principally residential treatment facilities), and up to $30,000 in Bluegrass MH/MR Board funds. In addition, the district office of the Department for Social Services has agreed to assign an existing staff person to the project as a service coordinator for Bluegrass IMPACT children. Additional time is being donated by community mental health center and Department for Mental Health staff.
6. *New state general fund allocations.* Each important strategy listed above can increase services for targeted children and lessen dependence on new state general fund allocations. Nevertheless, some new allocations of funds will be required to secure continuation of program activities during and beyond the Foundation funding period. The outlook for this is quite positive at this point. The Cabinet for Human Resources' *Plan to Address the Mental Health*

Needs of Kentucky's Children and Youth with Emotional Problems (1989) has been approved by the legislature and funded for fiscal years '91 and '92.

7. *Redirect from hospitals.* Budget language has been drafted that calls for the redirection of funds "made available by the reduction in mental hospital expenditures" to the development and provision of "community-based outpatient services and in-home services." This language was submitted to the appropriations and revenue committees for inclusion in the biennium budget for fiscal years '91 and '92. Rather than setting an arbitrary cap that can deny a child a needed placement with no alternatives available in the community, the Cabinet will coordinate the reduction in hospital care with the increasing community option.

Central to Kentucky's matching strategy is the idea that the project itself will generate a large amount of income in the form of reimbursement from Medicaid, private insurance, cash and in-kind donations, client fees, and other funding sources. The Bluegrass Mental Health/Mental Retardation Board is committed to seeing that project-generated income remains with the project. The Bluegrass MH/MR Board has developed a system for tracking project-related income and expenses. This is significant, not only to ensure that match occurs as planned, but also to provide data which will help other mental health centers to estimate similar service development.

Reducing Expenditures and Redirecting Funds from Hospitals to Community-Based Care

Due to the Cabinet's interest in and emphasis on preventing inappropriate institutionalization of emotionally disturbed children, a plan of action has been designed to reduce hospitalization of children in this state.

In an effort to eliminate unnecessary psychiatric hospital admissions and to reduce unnecessarily long hospital stays, the Department for Medicaid Services is taking a twofold action.

First, the requirements for a system of medical review of all psychiatric facility admissions for recipients of benefits under Title XIX of the Social Security Act (Medicaid) are being developed and will become the basis for a contract with an organization capable of completing these reviews. The reviews will determine if the psychiatric admissions are reasonable, medically necessary, furnished in the most appropriate setting, and of a quality which meets a professionally recognized standard of care. Only recognized mental health professionals will conduct reviews, some of which involve face-to-face evaluations of the persons seeking admission or continued stay.

Coupled with the development of this system and becoming an integral part of it is the development of new, more stringent admission criteria for inpatient psychiatric care reimbursable by Medicaid. The criteria are being developed in consultation with the Departments for Social Services and Mental Health/Mental Retardation Services and a group of child psychiatrists and psychologists practicing in Kentucky. A major effort is being made to strengthen the requirement for placement of persons in the least restrictive setting (including consultation with the regional interagency council to determine the availability of less restrictive alternatives), as well as to provide indicators of severity for criteria which might otherwise allow for a wide range of interpretation.

These changes in the Medicaid Program began on July 1, 1990. It is anticipated that the tightening of admission criteria and their application by qualified professionals will produce a reduction in improper inpatient psychiatric treatment in Kentucky.

As a result of these actions, the Medicaid census in mental hospitals is projected to decrease significantly over a 12- to 18-month period. During this period, the Department for Medicaid Services will monitor the effect of this reduced utilization on Medicaid reimbursement to mental hospitals to ensure that a reduction in bed days also means a reduction in Medicaid expenditures. Since mental hospital reimbursement is currently a prospectively determined, cost-based per diem payment, steps may need to be taken to ensure that the program does not pay for unused beds.

To the extent that a hospital's census would be reduced dramatically, it is presumed that an accompanying decrease would occur in their operating costs to a major extent. However, since capital cost is a fixed cost and would not decrease because of unused beds, the Department will consider imposing various occupancy factors to the capital cost that would reduce the Medicaid expenditure relating to fixed costs.

In summary, both a reduction in bed days and a reduction in Medicaid expenditures for this service are important components in Kentucky's efforts to expand community-based mental health services for youth. As stated in Kentucky's grant application to the Foundation, the Cabinet has made a commitment to redirect the funds made available by the reduction in mental hospital expenditures to the "development of community-based outpatient and in-home services." This language was proposed by the Cabinet and was approved by the House and Senate in the fiscal year '91–'92 budget memorandum.

Appendix G

The Ventura Model[1]

Ventura Model for Mental Health Services

The Ventura Model is a planning model for mental health reform.

Core Value

The Ventura Model is a community-based, interagency system of mental health care which targets the most disturbed children and provides the highest benefit to children, their families, and the community at the lowest cost to the public sector.

Values

- Common sense
- Clarity
- Simplicity

Ventura County Mental Health Planning Model

1. **Who?** In an environment of limited resources, who should receive priority for tax-supported mental health services?
2. **What?** What is the goal? What outcome do we hope to achieve? What is the purpose of the service?
3. **Where?** Where are the children located? Are other agencies involved? What resources are available?
4. **How?** What mental health services will enable the client to achieve the stated goal?
5. **Why?** Has the goal been achieved? What evidence demonstrates success or failure?

---

[1] Appendix G was written by
Randall Feltman LCSW,
Director,
Ventura County Mental Health Services,
Ventura, California

Five Essential Characteristics of the Ventura Model

1. Target client population
   - Justification
   - Definition
   - Identification
   - Assessment
2. Goal
   - Direction for services
3. Coalitions
   - Interagency collaboration
   - Public/private partnership
4. Mental health services and standards
   - Family preservation services
   - Family reunification services
   - Case management services
5. System accountability
   - Accountability
   - Cost avoidance
   - Marketing

Three Factors to Consider About Who Will Receive Priority

1. Risk

Children at greatest risk with a mental disorder should receive priority for limited tax-supported local mental health services.

A governor and legislators concerned about the future have an interest in redirecting the lives of children at greatest risk of becoming dysfunctional adults. Studies of today's incarcerated, homeless, chronically unemployed, and institutionalized adults reveal childhood and school histories of severe family conflict and breakdown, physical and sexual abuse, delinquent behavior, and school failure and dropout. In these histories, parents and teachers report unpredictable, impulsive, aggressive or destructive behavior, or depressed, withdrawn, isolated, and strange behaviors. These patterns are frequently manifestations of severe childhood mental disorders though few of these dysfunctional adults received any appropriate mental health treatment as children.

Early and premature separation from the family is a critical and usually irreversible event in their lives as children. Bouncing between divorced parents, multiple foster home placements, residential treatment placements, psychiatric hospitals, state hospitals, and incarceration in juvenile justice facilities were frequently part of the downward whirlpool cycle for these adults. Separation from family both reflects clinical severity and adds risk to the tenuous and damaged child's hope for the future. Even necessary separation adds risks for these children's chances to regain a place in their family, school, and community.

2. Legal Responsibility

Mentally disordered children with existing public agency legal responsibility should receive priority for limited tax-supported local mental health services.

When government by the action of a superior court judge or other court officer for protection or due to delinquent behavior takes legal and/or physical custody of a child from a parent, it assumes an awesome and heavy legal responsibility for that child. When a court ward or dependent has an identified mental disorder the judge has a legal responsibility and obligation to provide appropriate mental health assessment and treatment.

Under Public Law 94–142, disabled students have a right to receive an appropriate education at no cost to their parents. As part of an appropriate education, special education pupils are guaranteed mental health services "related" to their education as part of their individualized education plan. This law clearly establishes a legal responsibility and obligation to provide mental health services in these instances.

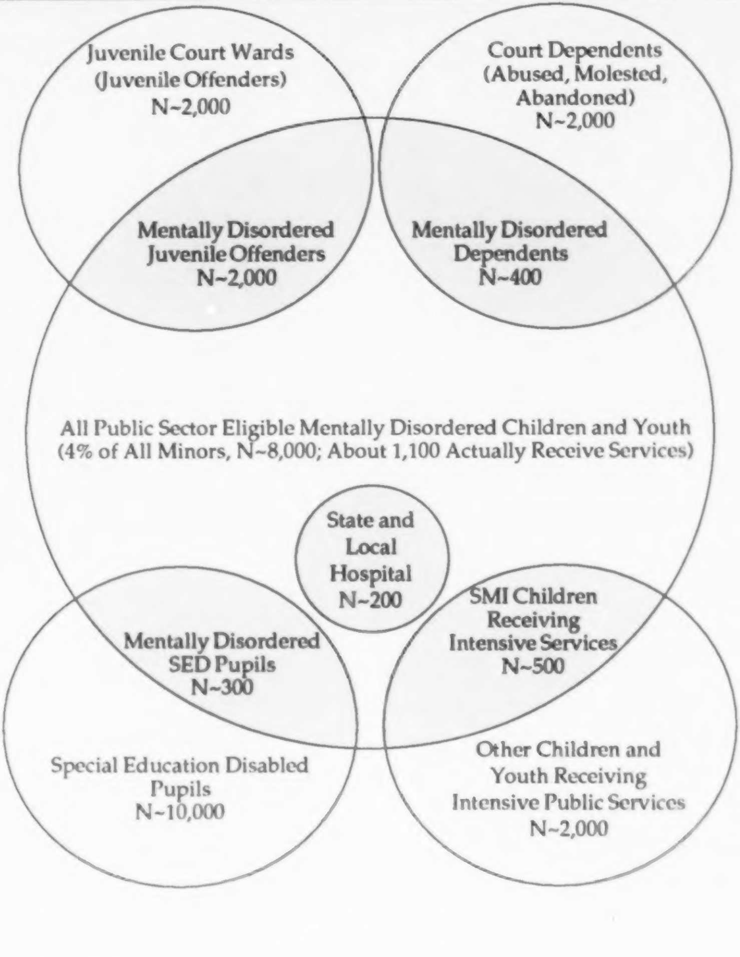
3. Fiscal Liability

Mentally disordered children who for lack of appropriate mental health services pose the greatest financial liability to the public should receive priority for the limited tax-supported local mental health services.

Public agency programs, including Special Education, Child Protective Services, Juvenile Justice and Mental Health, provide a continuum of services in graduated levels of restrictiveness and cost. Untreated seriously emotionally disturbed children fail at less restrictive levels of service and "graduate" to more restrictive and expensive levels. Foster home failures, special education class changes and failure, and probation violations, lead eventually to residential treatment placements, local and state hospital admissions, or incarceration. Tax-supported residential placements range from $25,000 to $75,000 per year; Medicaid and state psychiatric hospitals from $100,000 to $200,000 per year; and incarceration about $25,000 per year.

A system of less expensive local mental health services targeted to children separated or at imminent risk of separation with the goal of family maintenance or reunification can offset a major portion of the cost by reducing the number of children and length of stay in 24-hour facilities.

The Children and Youth Target Groups in the Ventura Model (Less than 1% of Ventura County children under 18 are included in the target population)


Juvenile Court Wards
(Juvenile Offenders)
N~2,000
Court Dependents
(Abused, Molested, Abandoned)
N~2,000
Mentally Disordered Juvenile Offenders
N~2,000
Mentally Disordered Dependents
N~400
All Public Sector Eligible Mentally Disordered Children and Youth
(4% of All Minors, N~8,000; About 1,100 Actually Receive Services)
State and Local Hospital
N~200
Mentally Disordered SED Pupils
N~300
SMI Children Receiving Intensive Services
N~500
Special Education Disabled Pupils
N~10,000
Other Children and Youth Receiving Intensive Public Services
N~2,000

VENTURA PLANNING MODEL TARGET POPULATIONS

Long-Term Mentally Disordered
Must have I, II, III, & IV:

I. Diagnosis
DSM III-R Axis I or II diagnosis, except a primary diagnosis of organic mental disorders, psychoactive substance use disorder, developmental disorder, or V code.

II. Functional impairments
Currently has, or historically has had, substantial impairment due to mental illness, in one of the following:

1. Independent living: Ability to provide basic needs, such as housing, hygiene, food, or money management.
2. Social relationships: Ability to establish or maintain social support systems to the extent that independent living or employment are jeopardized.
3. Vocational skills: Ability to obtain or maintain employment.
4. Physical condition: Somatization to the extent that public sector medical treatment is required.
5. Parenting/care giving: Ability to parent or care for dependent(s) to the extent that placement or public sector intervention has occurred or is imminent.

III. As a result of functional impairment, is eligible for/receiving public assistance, services, or entitlements, or otherwise a public responsibility or fiscal liability.

IV. Duration
Need for treatment may be lifelong.

Mentally Disordered Adults and Seniors
Must have (I & II) or (I & III):

I. Diagnosis
DSM III-R Axis I or II diagnosis, except a primary diagnosis of psychoactive substance use disorder, developmental disorder, or V code. Organic mental disorders are included only while behaviors are a danger to self or others.

II. Functional impairments/symptoms
Must have A or B:

- A. Functional impairments. Must have substantial impairment due to mental illness, in one of the following:
  1. Independent living: Ability to provide basic needs, such as housing, hygiene, food, or money management.
  2. Social relationships: Ability to establish or maintain social support systems to the extent that independent living or employment are jeopardized.
  3. Vocational skills: Ability to obtain or maintain employment.
  4. Physical condition: Somatization to the extent that public sector medical treatment is required.

5. Parenting/care giving: Ability to parent or care for dependent(s) to the extent that placement or public sector intervention has occurred or is imminent.

B. Symptoms. Must have *one* of the following:
   1. Psychotic symptoms.
   2. Suicidal risk.
   3. Violence: At risk for causing injury to person or significant damage to property, due to a mental illness.

III. History
History demonstrates that without treatment there is imminent risk of decompensation to functional impairments/symptoms in section II, above.

Mentally Disordered Children and Youth
Must have (I, II and III) or (I, II & IV) or V:

I. Diagnosis
DSM III-R Axis I or II diagnosis, except a primary diagnosis of psychoactive substance use disorder, developmental disorder, or V code. Organic mental disorders are included only while behaviors are a danger to self or others.

II Risk of separation from family
Risk of or separated from family due to, for example: (1) Chronic family dysfunction involving a mentally ill and/or inadequate caretaker, or multiple agency contacts, or changes in custodial adult; or (2) going to, residing in, returning from any out-of-home placement, e.g., psychiatric hospital, short-term inpatient, residential treatment, group or foster home, corrections facility, etc.

III. Functional impairments/symptoms
Must have A or B:

A. Functional impairment. Must have substantial impairment in *two* of the following capacities to function (corresponding to expected *developmental level)*:
   1. Autonomous functioning.
   2. Functioning in the community.
   3. Functioning in the family or family equivalent.
   4. Functioning in school/work.

B. Symptoms. Must have *one* of the following:
   1. Psychotic symptoms.
   2. Suicidal risk.
   3. Violence: at risk for causing injury to person or significant damage to property, due to a mental illness.

IV. History
Without treatment there is imminent risk of decompensation to functional impairments/symptoms in section II, above.

V. Special education eligible under Chapter 26.5 of the California Education Code (AB 3632).

Note: An appeal process is established for exceptions. Please see accompanying text for explanations and more detailed descriptions.

Functional Impairments/Symptoms

Must have A and B or A and C.

A. *Separation from family.* Is out-of-home, or presents with significant risk factors associated with out-of-home placement instate, etc.

B. *Functional impairment.* Must have significant impairment in two of the following: present 6 months or more (unless specifically stated otherwise) and likely to continue with significant intensity and duration if not treated.

1. Developmentally appropriate self-care
2. Quality of interpersonal relationships
    a. Relationship with peers: criteria same as those noted in impaired basic skills.
    b. Relationship with adults: limited contact or avoidant behavior with adults in school/social setting, unresponsive, conflict/tension characterize relationships, extremely fearful of adult/teacher contact, forms rapid and intense relationships.
    c. Frustration tolerance: easily frustrated, reacts with verbal/physical threats in social situations, controls through intimidation, acquiesce to demands, follower.
3. The child's capacity to function autonomously, related to his or her age
    a. Self-direction: inability for self-direction/indecisive or hesitant, over-reliance on others, intense need for attention, notable developmental delays; specify.
    b. Reality testing and problem awareness: incorrect judgments about current situations; including school, family, peers, other social relationships or future plans; strong denial.
    c. Congruent affective presentation: labile affect, depressive, ideation, sullen expression/attitude, bizarre behavior and mannerisms, excessive speech, overly dramatic presentation, elevated expression/energy level, chronic angry expression, irritable and argumentative.
4. Current functioning in family or family equivalent
    - Problem solving: inability to solve instrumental/affective tasks.
    - Communication patterns: clear vs. masked, direct vs. indirect.
    - Affective expression and involvement: total abstinence, narcissistic, empathic, symbiotic.
    - Behavioral control: rigid, laissez faire, chaotic.
    - Autonomy vs. enmeshment: inability to make separate choices, think or feel differently, disagree.
5. Degree to which child uses his or her ability for academic functioning (Rg/O intellectual, sensory, or other health factor);

replaces an inability to learn which cannot be explained by intellectual, sensory or other, etc.

   a. Age/grade: competency level, academic performance given current curriculum, careless performance.
   b. Classroom performance: unmotivated, exhibits off-task behavior, attention and concentration appear impaired.
   c. Socialization skills inappropriate to developmental level: chronically disruptive, engages students negatively, or isolated by peers.

6. Child's vulnerability in the face of significant environmental stressors
   a. Mental status of parent(s), related to major psychopathology: do parents fit VCMH target population definitions?
   b. Significant life-altering transitions, i.e., death of significant family member, natural disaster—6 months duration is not necessary. (Divorce would qualify in specific situations.)

Risk Factors

Placement

- Past acute hospitalizations
- History of foster home failure
- Child on waiting list for day treatment/residential care
- Child in group home but acting out behavior is threatening placement
- Child returning from residential placement

Psychosocial/family

- Significant family disorganization as evidenced by use of voluntary temporary out-of-home placements (i.e., relatives)
- Significant family disorganization as evidenced by legal involvement with Child Protective Services or juvenile probation
- Child has a major mental illness
  a. schizophrenia
  b. major depression
- Frequent probation violations with threat of incarceration
- Child has received no prior services from any agency but presents with significant impairment and family is requesting placement
- A parenting family member or significant other has a major mental illness

Educational

- Pupil on home teaching

CHILDREN AND YOUTH TARGET POPULATION REVIEW FORM

Client Name ______________ Age ________ ID # ________

Clinician ______________ Admission Date ________

CRITERIA: Client Must Have (I & II) *or* (I & III) *or* IV:

I. **DSM III Diagnosis:** ________ **Medication:** ________

II. **Risk of or separation from family:** Circle all that apply.
Is out-of-home or at risk of out-of-home placement in state or local psychiatric hospitals, residential treatment programs, therapeutic group or foster-care homes, corrections facilities, etc.

1. State/other psychiatric hospital
2. Residential treatment
3. Foster care
4. Other: ________

Specific examples: ______________

III. **Functional impairments/symptoms:** Must have A *or* B:

A. Functional impairment. Must have substantial impairment in *two* of the following capacities to function (corresponding to expected *developmental level*):

1. Autonomous functioning
2. Functioning in the community
3. Functioning in the family or family equivalent
4. Functioning in school/work

Specific examples: ______________

B. Symptoms. Must have *one* of the following:

1. Psychotic symptoms
2. Suicidal risk
3. Violence: At risk for causing injury to person or significant damage to property, due to a mental illness

Specific examples: ______________

IV. **History**
Without treatment there is imminent risk of decompensation to functional impairments/symptoms in section III, above.
Document specific symptoms or impairments expected without treatment:

V. **Special Education Eligible Under Chapter 26.5 of the California Education Code (AB 3632).** ☐ **Yes** ☐ **No**

Additional Comments: ______________

Suggested Target Population Category: ___ Suggested Treatment Modality: ___

Clinician's Signature: ________ Date: ________

REVIEW COMMITTEE DECISION

Accept: ________ Target Population Category: ___

Treatment Modality: ________

Refer Out: ________ Referral to: ________

Comments: ______________

- Current enrollment in SED class

Positive Goal Attributes

- Clear and understandable
- Observable and measurable: Did we make a difference?
- Marketable: Is it a good reason to spend tax dollars?
- Interagency support: Does the goal complement or enhance other agency's goals?
- Client benefit and cost avoidance: Are they both present?

Ventura County Mental Health Goal

The primary goal of the Ventura County Mental Health Services is to enable seriously emotionally disturbed children to remain with their family/foster family, attend and progress in public school, and not commit crimes.

This goal includes:

- Reducing the rate of removal from the home,
- Reducing court-ordered residential placements of wards and dependents, especially out-of-county,
- Reducing recidivism by juvenile offenders,
- Reducing state and local hospitalization,
- Reducing out-of-county nonpublic school residential placements, and
- Improving school performance and attendance.

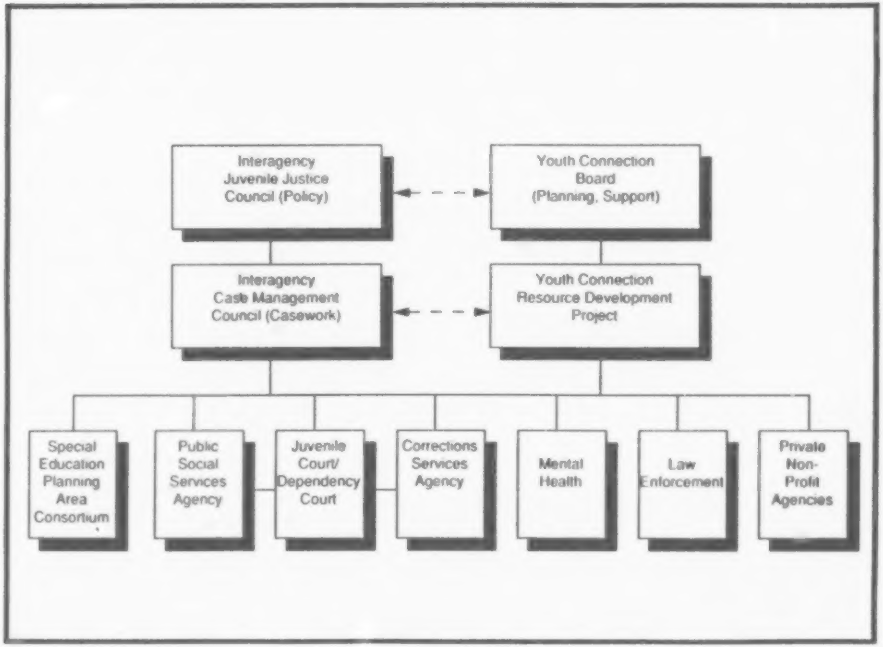
Coalitions

Interagency Collaboration

- Multiproblem child and family
- Shared responsibility
- Mutual benefit
- Leverage
- Power and control
- Natural environment

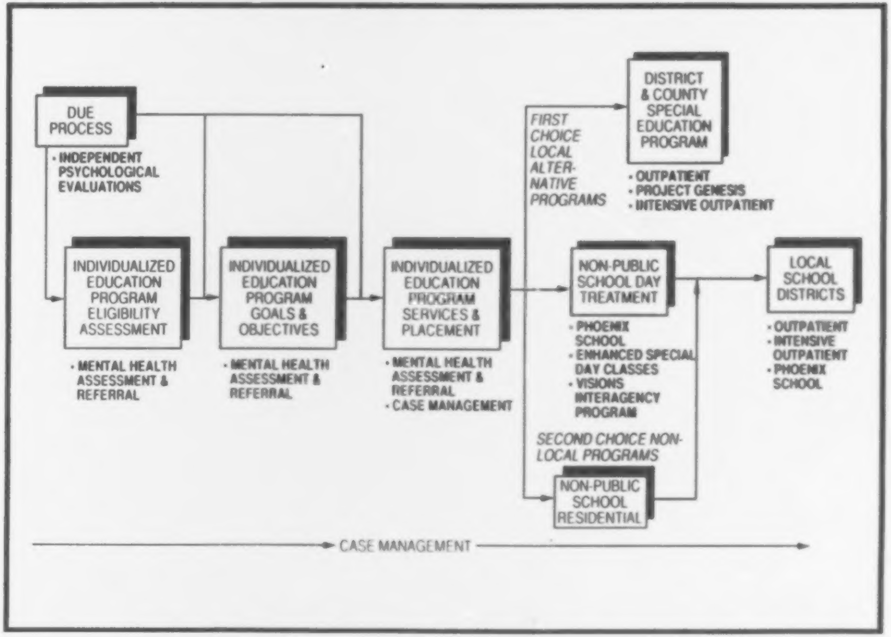
Public/Private Partnership

- Community organization
- Focus on the public agency child


Interagency Juvenile Justice Council (Policy)
Youth Connection Board (Planning, Support)
Interagency Case Management Council (Casework)
Youth Connection Resource Development Project
Special Education Planning Area Consortium
Public Social Services Agency
Juvenile Court/ Dependency Court
Corrections Services Agency
Mental Health
Law Enforcement
Private Non-Profit Agencies

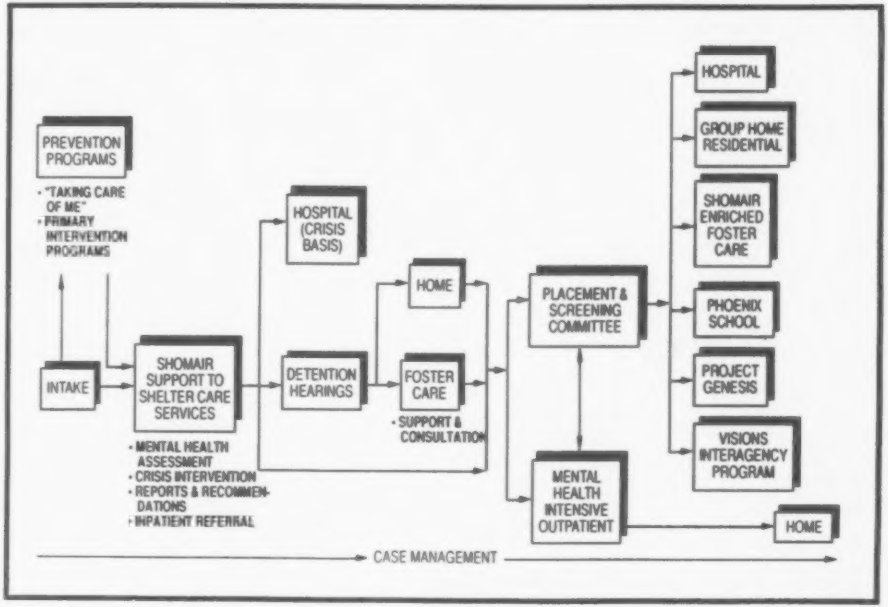
Ventura County Interagency Network

BEST COPY AVAILABLE

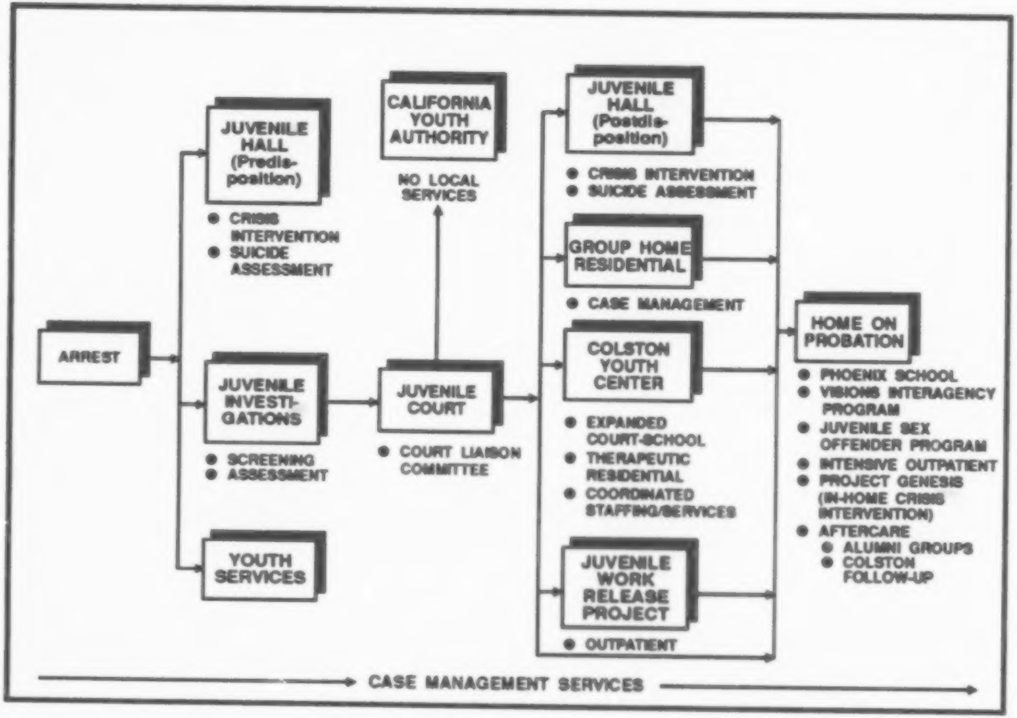


Special Education Sub-System

DUE PROCESS
• INDEPENDENT PSYCHOLOGICAL EVALUATIONS
INDIVIDUALIZED EDUCATION PROGRAM ELIGIBILITY ASSESSMENT
• MENTAL HEALTH ASSESSMENT & REFERRAL
INDIVIDUALIZED EDUCATION PROGRAM GOALS & OBJECTIVES
• MENTAL HEALTH ASSESSMENT & REFERRAL
INDIVIDUALIZED EDUCATION PROGRAM SERVICES & PLACEMENT
• MENTAL HEALTH ASSESSMENT & REFERRAL
• CASE MANAGEMENT
FIRST CHOICE LOCAL ALTERNATIVE PROGRAMS
DISTRICT & COUNTY SPECIAL EDUCATION PROGRAM
• OUTPATIENT
• PROJECT GENESIS
• INTENSIVE OUTPATIENT
NON-PUBLIC SCHOOL DAY TREATMENT
• PHOENIX SCHOOL
• ENHANCED SPECIAL DAY CLASSES
• VISIONS INTERAGENCY PROGRAM
SECOND CHOICE NON-LOCAL PROGRAMS
NON-PUBLIC SCHOOL RESIDENTIAL
LOCAL SCHOOL DISTRICTS
• OUTPATIENT
• INTENSIVE OUTPATIENT
• PHOENIX SCHOOL
CASE MANAGEMENT


PREVENTION PROGRAMS
• "TAKING CARE OF ME"
• PRIMARY INTERVENTION PROGRAMS
INTAKE
SHOMAIR SUPPORT TO SHELTER CARE SERVICES
• MENTAL HEALTH ASSESSMENT
• CRISIS INTERVENTION
• REPORTS & RECOMMENDATIONS
• INPATIENT REFERRAL
HOSPITAL (CRISIS BASIS)
DETENTION HEARINGS
HOME
FOSTER CARE
• SUPPORT & CONSULTATION
PLACEMENT & SCREENING COMMITTEE
MENTAL HEALTH INTENSIVE OUTPATIENT
HOSPITAL
GROUP HOME RESIDENTIAL
SHOMAIR ENRICHED FOSTER CARE
PHOENIX SCHOOL
PROJECT GENESIS
VISIONS INTERAGENCY PROGRAM
HOME
CASE MANAGEMENT

Juvenile Justice Sub-System


ARREST
JUVENILE HALL (Predisposition)
• CRISIS INTERVENTION
• SUICIDE ASSESSMENT
JUVENILE INVESTIGATIONS
• SCREENING
• ASSESSMENT
YOUTH SERVICES
CALIFORNIA YOUTH AUTHORITY
NO LOCAL SERVICES
JUVENILE COURT
• COURT LIAISON COMMITTEE
JUVENILE HALL (Postdisposition)
• CRISIS INTERVENTION
• SUICIDE ASSESSMENT
GROUP HOME RESIDENTIAL
• CASE MANAGEMENT
COLSTON YOUTH CENTER
• EXPANDED COURT-SCHOOL
• THERAPEUTIC RESIDENTIAL
• COORDINATED STAFFING/SERVICES
JUVENILE WORK RELEASE PROJECT
• OUTPATIENT
HOME ON PROBATION
• PHOENIX SCHOOL
• VISIONS INTERAGENCY PROGRAM
• JUVENILE SEX OFFENDER PROGRAM
• INTENSIVE OUTPATIENT
• PROJECT GENESIS (IN-HOME CRISIS INTERVENTION)
• AFTERCARE
• ALUMNI GROUPS
• COLSTON FOLLOW-UP
CASE MANAGEMENT SERVICES

BEST COPY AVAILABLE

Leverage

The Colston Intensive Residential Program has 45 beds and is a local alternative to out-of-county placement.

The budget includes:

- $550,000 existing probation budget
- $225,000 county schools budget. This includes $100,000 of existing funds and $125,000 of reallocated local funds.
- $340,000 mental health budget. This includes $60,000 of existing funds and $280,000 of new state mental health funding.

The total program budget is $1,115,000. This includes 25% for new mental health funds.

Private Sector—Ventura County Youth Connection

Purpose

- Create policy and develop plans to provide for the unmet needs of high-risk youth.
- Ensure that the Youth Connection's role is complementary to that of the public sector.
- Develop voluntary services and financial participation for needed services.
- Advocate for high-risk youth in private and public forums to ensure that needed services are provided.

Membership

- Business leaders
- Professional practitioners
- Religious community leaders
- Juvenile court judge
- Member of the Board of Supervisors

Staff Support

- Mental health department
- Public social services agency
- Interface family services

Youth Resources Project

- Bank of goods and services worth more than $700,000.
- Has served more than 400 children to date, providing more than $500,000 in goods and services.

Youth Services Inventory

The following are identified needs and possible providers. Hours or units listed after some services represent a suggested minimum donation for membership. Those not defined would require consultation from representatives of that profession.

Services

1. Individual and family therapy and counseling providers (6 hours):
   - Psychiatrists
   - Psychologists
   - Clinical social workers
   - Marriage, family and child counselors
2. Alcohol counseling (6 hours) providers:
   - Licensed therapists
3. Drug counseling (6 hours)
   - Licensed therapists
4. Psychological evaluation (1)
   - Psychologists
5. Dental exams, nonMedi-Cal covered dental work—teeth cleaning, orthodontia—providers:
   - Dentists
   - Orthodontists
6. Eye exams, prescription glasses (1 each) providers:
   - Optometrists
   - Opticians
   - Ophthalmologists
7. Physical exams—Medical care providers:
   - Pediatricians
   - Family practitioners
8. Hearing evaluations providers:
   - Audiologists
9. Tutoring (10 hours) providers:
   - Teachers
   - Volunteers (high-school students, college students and other adults)
10. Speech therapy (10 hours) providers:
    - Speech therapist
11. Infant stimulation (10 hours) providers:
    - Occupational therapist
12. Transportation (10 trips within county) providers:
    - Volunteers

13. Employment opportunity (1) providers:
    - Employers
14. Home finding assistance (secure one rental):
    - Volunteers
15. Big Brothers/Big Sisters (6 months YRP referral)
    - Volunteers
16. Office assistance for YRP-casework for YRP clients
    - Volunteers

Goods

- Clothing
- Prescription and nonprescription medicine not covered by Medi-Cal.
- Gift items—birthdays, Christmas, graduation
- Bicycles
- School supplies

The Ventura Model Continuum of Care Elements

1. Prevention
    - Consultation, education, information services
    - Primary prevention project (2)
2. Emergency service
    - Outpatient crisis service
    - Genesis outreach
3. Outpatient
    - Ventura–Santa Paula–Ojai
    - Oxnard–Camarillo
    - Simi–Conejo–Moorpark
4. Day Care
    - Phoenix school
    - VIP day care
5. Case Management
    - Countywide
6. Crisis intervention homes (6 beds)
    - Child Protective Services
7. Enriched foster homes
    - Shomair homes (25 placements)
8. Transitional residential
    - Colston Youth Center (45 beds) (Juvenile Justice)
    - Santa Rosa Treatment Home (4 beds)
    - Special Education Residential (6 beds)

9. Acute psychiatric hospital
   - Adult inpatient (children, adolescents integrated with adults)
10. Long-term residential
    - Private title AFDC group homes—within and out-of-county
11. Secure regional intensive treatment center
    - Camarillo State Hospital
      Children's program (3 placements)
      Adolescent program (4 placements)

Services and Standards

Family Preservation Programs

- Intensive outpatient services
- Enriched SED classes
- Juvenile sex offender program
- Genesis crisis program
- Phoenix and VIP day care programs
- Shomair enriched foster care
- Youth connection resources project

Family Reunification Programs

- Colston Intensive Intervention Program
- Interface Crisis Treatment Home
- Santa Rosa Treatment Home

Management

- Mental health case management (25:1)
- Juvenile Justice screening committee
- Protective Services placement screening committee
- Expanded special education IEP teams for Assembly Bill 3632 and all residential candidates
- Interagency Case Management Council

Comments

- Least restrictive, least intrusive, least expensive
- Services designed for the individual child
- Builds on local resources
- Alternatives to costly hospitalization and residential placement

- Goal directed
- Case managers are brokers of the system

Mental Health Case Management Functions

Basic Responsibilities:

Assessment

- Interviews with child, family, significant others
- Consultation with public and private agencies involved
- Obtain and evaluate court, school, medical, and mental health records

Planning

- Develop service/treatment plan
- Collaboration with public and private agencies involved

Linking

- Prepare child and family for placement
- Appear in court on child's behalf
- Prepare placement packet, contact facilities, mail packet
- Transport for preplacement interview and to final placement
- After discharge: Facilitate the aftercare engagement and the service plan

Monitoring

- Monthly visit to child and agency staff to assess treatment progress
- Monthly progress reports to protective services, probation, or special education team
- PRN contacts with family
- PRN meeting with other agencies and participate in discharge planning

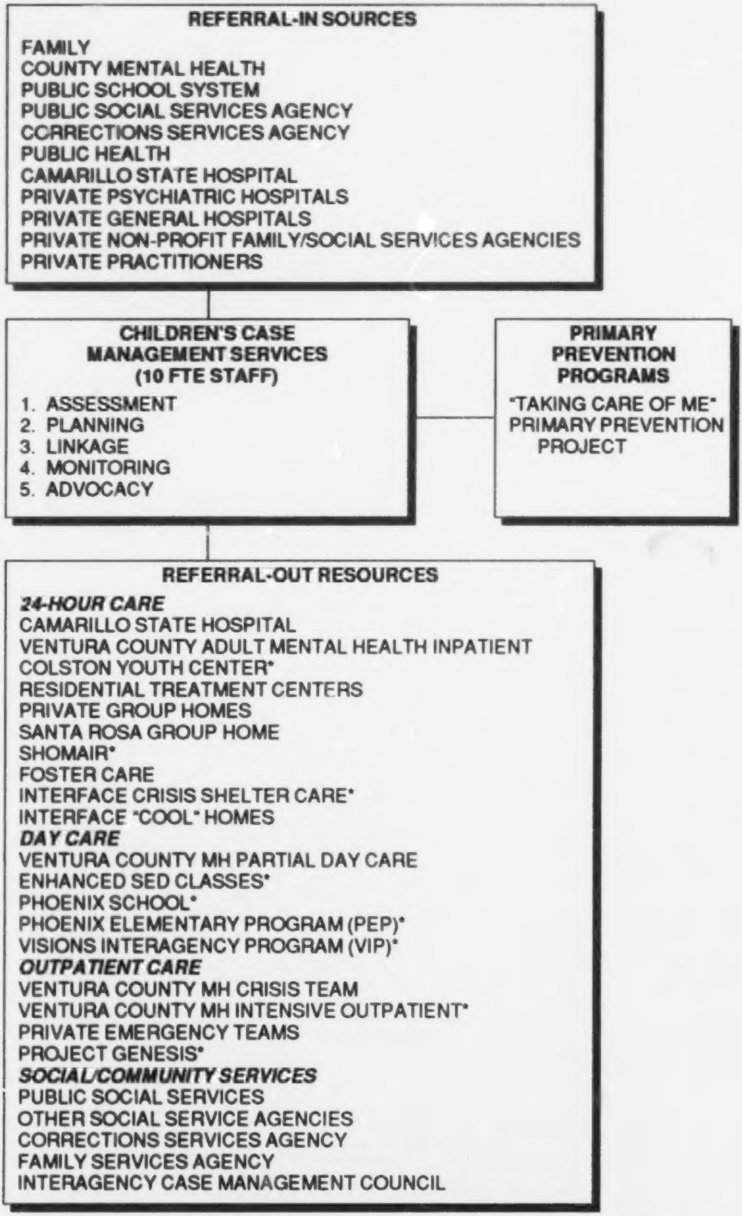
Advocacy

- Secure other financial and service assistance including SSI, medical, victims witness, Youth Connection, Interagency Case Management Council, Interface Children's services, and private insurance

Additional Tasks:

Special Education Services

- Assess for daytreatment services and out-of-home placement
- Submit written report to Individual Education Plan Team and attend team meetings



REFERRAL-IN SOURCES

FAMILY
COUNTY MENTAL HEALTH
PUBLIC SCHOOL SYSTEM
PUBLIC SOCIAL SERVICES AGENCY
CORRECTIONS SERVICES AGENCY
PUBLIC HEALTH
CAMARILLO STATE HOSPITAL
PRIVATE PSYCHIATRIC HOSPITALS
PRIVATE GENERAL HOSPITALS
PRIVATE NON-PROFIT FAMILY/SOCIAL SERVICES AGENCIES
PRIVATE PRACTITIONERS

CHILDREN'S CASE MANAGEMENT SERVICES (10 FTE STAFF)

1. ASSESSMENT
2. PLANNING
3. LINKAGE
4. MONITORING
5. ADVOCACY

PRIMARY PREVENTION PROGRAMS

"TAKING CARE OF ME" PRIMARY PREVENTION PROJECT

REFERRAL-OUT RESOURCES

24-HOUR CARE
CAMARILLO STATE HOSPITAL
VENTURA COUNTY ADULT MENTAL HEALTH INPATIENT
COLSTON YOUTH CENTER*
RESIDENTIAL TREATMENT CENTERS
PRIVATE GROUP HOMES
SANTA ROSA GROUP HOME
SHOMAIR*
FOSTER CARE
INTERFACE CRISIS SHELTER CARE*
INTERFACE "COOL" HOMES
DAY CARE
VENTURA COUNTY MH PARTIAL DAY CARE
ENHANCED SED CLASSES*
PHOENIX SCHOOL*
PHOENIX ELEMENTARY PROGRAM (PEP)*
VISIONS INTERAGENCY PROGRAM (VIP)*
OUTPATIENT CARE
VENTURA COUNTY MH CRISIS TEAM
VENTURA COUNTY MH INTENSIVE OUTPATIENT*
PRIVATE EMERGENCY TEAMS
PROJECT GENESIS*
SOCIAL/COMMUNITY SERVICES
PUBLIC SOCIAL SERVICES
OTHER SOCIAL SERVICE AGENCIES
CORRECTIONS SERVICES AGENCY
FAMILY SERVICES AGENCY
INTERAGENCY CASE MANAGEMENT COUNCIL

---

* = Resources added by the Demonstration Project.

Community Service

- Assessment and referral services to nontarget population, children and families, schools, protective services, probation, private practitioners, private psychiatric hospitals, and family social service agencies

Limited Direct Service

- Crisis intervention services for child and families during placement transitions
- Facilitate acute psychiatric hospitalization when not linked to direct treatment provider

System Monitoring

Tracks Clients

- Follows children over time and across agencies
- Combined by target groups for analyses

External, Observable Indicators of Success

- All public costs
- Recidivism of juvenile offenders
- Public school attendance and performance
- Clients at home and in local community
- Interagency policy, planning, and case management, and fulfillment of interagency agreements

Advantages

- Full accountability to client, family, funding agency
- Measures cost avoidance and savings to federal, state, and county agencies
- Feedback loop between management and evaluation monitors critical success factors and identifies areas for management action

1989 CHILDREN'S SERVICE PROGRAM AND FISCAL OVERVIEW
Ventura County Mental Health

Mode/Program Name	*Location*	*Revenue*					
		S/D	*Grant*	*Medi-Cal*	*Insurance*	*UMDAP*	*Other Agency*
Prevention							
1. Primary Intervention Project	Two School Districts		•				Ed.
2. Student Support Services Project	County School District	•					Ed.
Emergency							
1. Juvenile Hall Screening	Juvenile Hall	•					CSA
2. Shelter Care Screening	Foster Homes	•					PSSA
3. Genesis In-home Intervention	Client's Residence	•					Interface
4. Central Crisis Team	Ventura MH	•		•	•	•	
Outpatient							
1. Outpatient	Clinic and Outreach	•		•	•	•	
2. Enriched SED Classes (8)	School Sites	•					Ed.
3. Juvenile Sex Offender Project	Ventura		•				
Day Treatment							
1. Phoenix School	School Sites	•					Ed.
2. Visions Interagency Program	School Sites	•				•	Ed.
Case Management							
1. Case Management	County-wide	•					
Crisis Residential							
1. Interface Crisis Residential Home	Oxnard	•					PSSA Interface
Transitional Residential							
1. Enriched Foster Care (15)	County-wide	•					PSSA
2. Colston Intensive Intervention Program	County Detention Center	•					CSA, Ed.
3. Santa Rosa Treatment Home	Camarillo	•				•	PSSA
4. Private Placements	Group Homes						PSSA, CSA, Ed.
Acute Hospital							
1. County Inpatient Unit	Ventura MH	•		•	•	•	
2. Vista Del Mar Hospital (Private)	Ventura						
State Hospital							
1. Camarillo State Hospital	Camarillo						
Evaluation							
Administration							
County Overhead							
Total FTEs							
Local Beds Community-Based Beds							
Group Homes and Hospital-Based Beds							
Total Beds/Clients Served							
Total Mental Health Dollars							

1989 CHILDREN'S SERVICE PROGRAM AND FISCAL OVERVIEW
Ventura County Mental Health (Continued)

FTEs/ Beds	*Number of Clients Served*	*Mental Health Funds*	*Comments*
1 FTE	NA	$ 57,723	3-year grant from State Department of Mental Health
.5 FTE	NA	$ 24,522	Social-emotional curriculum development
1.6 FTE	205	$ 45,900	Primary focus is suicide prevention
1.0 FTE	350	$ 36,817	
4 FTE	50	$ 150,000	Contract
.5 FTE	100	$ 20,000	Primary contacts with adults in crisis
11.5 FTE	300	$ 500,000	
5 FTE	160	$ 271,000	Assembly Bill 3632 funds, five school sites
2 FTE	25	$ 150,000	3-year grant from OCJP
4.5 FTE	22	$ 222,100	16 day treatment slots, special education
2.1 FTE	10	$ 90,000	24 day treatment slots, regular education (new)
10.2 FTE	320	$ 494,400	Brokers for the system
6 beds	5	$ 87,310	Contract
20 beds	28	$ 100,000	3.2 FTE
45 beds	125	$ 326,500	Added 6 FTE to create residential treatment program
4 beds	10	$101,000	Contract
85 beds	100	$ 249,211	AFDC-FC funded, small mental health patch
2 beds	4	$ 270,100	Gross cost at $370 per day
4 beds	30	$ 13,500	MD contract
5 beds	10	$ 473,405	Gross cost at $259.40 per day
1.5 FTE		$ 125,000	Includes computer support services
2 FTE		$ 86,700	
		$ 521,916	Agency and county support
47.4 FTE			
71 beds			
100 beds	1,854		Ventura County Mental Health cost summary:
171 beds			Population = 629,000 (31.8% under 18 = $22.08 per child)
		$4,417,104	Target population = 1,879 = $2,351 per child per year

Monthly Placement Report
June 1989

AFDC Group Home Placements

82	Total group home placements—in and out-of-county
51	Total court dependents
31	Total court wards
24	Total in-county
12	Court dependents
12	Court wards
58	Total out-of-county
39	Court dependents
19	Court wards

Nonpublic School Residential Placements

7	Total special education—Assembly Bill 3632 (IEP team decision)
18	Total court dependents (court-initiated)
1	Total court wards (court-initiated)
1	Total privately funded

Special Education Residential Placements

7	Total in nonpublic school
7	Total in public school

State Hospital

6	Current census
0	Admissions
0	Discharges

Other Residential Treatment Placements

24	Shomair (Mental Health Team) enriched foster homes
3	Santa Rosa Treatment Home (4 beds)
5	Interface Crisis Residential (6 beds)

Assembly Bill 377 Legislative Background

1. **Public Law 94–142, 1975 (Federal Law). Special Education.** Assures that all handicapped children have a free and available public education and emphasizes special education and related services, including mental health.
2. **Assembly Bill 3121, 1976. Juvenile Justice.** Probation officer authorized to provide services to a child, including shelter care, crisis resolution homes, and counseling or education centers, in lieu of placement in secure custody solely because the child is described by Section 601, beyond parental control.
3. **Assembly Bill 1339, 1978. Mental Health.** Requires each county mental health to allocate 50% of new funds to children's programs until amount expended is at least 25% of gross budget.
4. **Assembly Bill 3052, 1979. Mental Health.** Provides for a continuum of day care and residential treatment programs for children that

Results—Benefit to the Child

Goals Required by Assembly Bill 377

The State Department of Mental Health shall determine that the demonstration project has achieved substantial compliance with all of the following goals.

Project Goals to be Met	*Project Outcome*	*Has Substantial Compliance Been Achieved?*
2. A 20% reduction in out-of-county court-ordered placements of juvenile justice wards and social service dependents.	Down 25%	Exceeded
3. A statistically significant reduction in rate of recidivism by juvenile offenders participating in the demonstration project.	Offenders down 56% Episodes down 52% Days down 30%	Exceeded
4. A 25% reduction in rate of state hospitalizations of minors from the baseline fiscal year 1980–81 level.	Down 72%	Exceeded
5. A 10% reduction in out-of-county nonpublic school residential placements of special education pupils.	Down 33%	Exceeded
6. Allow at least 50% of children at risk of imminent placement served by the intensive in-home crisis treatment program to remain at home at least 6 months.	91% have stayed at home more than 6 months	Exceeded
7. Statistically significant improvement in school attendance and academic performance of mentally disordered special education pupils treated in the demonstration project's day treatment program	Significant gains in attendance and academic performance	Exceeded

would serve as an alternative to more costly and restrictive hospital placement.

5. **Assembly Bill 1870, 1980. Special Education.** Defines state responsibility for special education. For example, defines procedures for assessment of handicapped students, calls for placement in the least restrictive setting, defines psychotherapy as a "related service," and calls for written interagency agreements.
6. **Public Law 96–398, 1980 (Federal Law). Mental Health.** Found that unserved and underserved populations remain, such as children and youth, who need mental health services. Priorities for SED (seriously emotionally disturbed) children include identification and assessment, availability of appropriate personnel, provision of mental

Results—Cost Avoidance

Short- and Long-Term Cost Avoidance

Total cost avoidance in the categories listed in subdivision (a) of Assembly Bill 377 must exceed 50% of demonstration project costs

Short-Term Costs Avoided	*Costs Avoided*	*Percent of Project Costs ($1,461,409)*
1. Group home costs paid by Aid to Families with Dependent Children–Family Care (AFDC–FC)	$306,000	20.9%
2. Children and adolescent state hospital programs.	$420,600	28.8%
3. Nonpublic school residential placement costs.	$127,312	8.7%
5. Other short- and long-term savings in public funds resulting from the demonstration project: Assembly Bill 3632 placement cost avoidance	$ 71,336	4.9%
Total Short-Term Cost Avoidance	**$925,248**	**63.3%**
Long-Term Costs Avoided		
4. Juvenile Justice reincarcerations	$160,020	10.9%

health services for handicapped students, and cooperative arrangement with other agencies serving these children.

7. **Public Law 96–272. (Federal Law). Social Services.** Directs reasonable efforts to be made to prevent "foster care drift" by eliminating the need for the child to return to his home or enter a permanent placement. Provides for case plans and timely review. Designed to limit temporary foster care to 18 months.
8. **Assembly Bill 2315, 1981. Mental Health.** Sought to develop a planning model for a continuum of mental health care for emotionally disturbed children that would promote appropriate treatment in the least restrictive and costly environment. Intended to prevent unnecessary state hospital and residential placement.
9. **Senate Bill 14, 1982. Social Services.** California's interpretation of Public Law 96–272. The court shall make a determination based on the provision of reasonable services to the child and parents/guardians that the child should be returned or permanently removed from the home, includes criteria for termination of parents' rights. Designed to limit placement to 12 months.
10. **Assembly Bill 2381, 1984. Mental Health.** Legislative intent was to ensure the most cost efficient, flexible, and effective system of mental health programs possible, foster innovation and experimentation, and provide alternatives to institutional settings. Emphasized direct family work.

11. **Assembly Bill 3632, 1984. Special Education.** Intent was to maximize and coordinate state and local agencies serving handicapped children. Mental health is responsible for provision of related mental health services and lead case management and participates on IEP Teams when residential placement is considered. Diverts children from residential to nonresidential services.
12. **Assembly Bill 3920, 1984. Mental Health.** Established a 2-year demonstration project in Ventura County to design and implement a replicable, comprehensive, coordinated children's mental health system building on existing interagency services. Gave priority to services designed to keep child in usual family residence. Required evaluation for effectiveness of treatment and cost benefit on an ongoing basis.
13. **Assembly Bill 2541, 1985. Mental Health.** Omnibus legislation for all age groups. Mentally disordered children are a priority group and families must be integrated in treatment plans when appropriate. County mental health has responsibility to assess court wards and dependents and determine the level of involvement to assure access to appropriate treatment. Requires a county plan for a coordinated system of services for SED children.
14. **Assembly Bill 2704, 1986. Mental Health.** Identifies importance of mental health case management for children and encourages development of these services for children separated from their families. Children's case management is defined differently from adult case management.
15. **Assembly Bill 377, 1987. Mental Health.** Added measurable client and cost outcome goals to the Ventura County demonstration project. When substantial compliance was achieved during the third year of the project, Assembly Bill 377 extended the Ventura Model to other counties with availability of funding.
16. **Assembly Bill 3777, 1988. Mental Health.** Extended the Ventura Model to adults and seniors. Provided for 4-year demonstration project to evaluate the Ventura Model and integrated service agencies with availability of funding.

Assembly Bill 377 Implications

- Provides needed treatment to the most seriously emotionally disturbed children for whom the public sector has legal responsibility and fiscal liability.
- New funds leverage reform of existing mental health system.
- Initiates outcome evaluation of benefits and public expenditures which provides new fish bowl accountability.

- Creates partnerships among human service agencies at state and county level. Clarifies state and local responsibilities.
- Justifies mental health assessment, treatment, and case management as essential human services in an environment of limited public funding resources.
- Builds partnerships with the private sector and targets available private sector resources to public agency children.

SERIOUSLY EMOTIONALLY DISTURBED CHILDREN—PUBLIC SECTOR COSTS

FINANCIAL SURVEY

(All questions refer to a county, regional, district, or other local jurisdiction)

1. What is the local mental health budget? ______________
2. What percentage is spent on programs for children and youth? ________
3. How much is spent on children and youth in state hospitals? ________
    Total annual cost? ______________
    Number of clients? ______________
    Cost per day? ______________
    Cost per episode? ______________
4. How much Medi-Cal/Medicare is spent on psychiatric hospitalization for children and youth? ______________
    Number of clients? ______________
    Cost per day? ______________
    Cost per episode? ______________
    Total annual cost? ______________
5. How many SED students are in nonpublic schools per Public Law 94–142? ______________
    What is the total annual cost? ______________
    Average cost per month? ______________
    Average length of stay? ______________
    Average cost per episode? ______________
6. How many Public Law 94–142 Fair Hearings related to nonpublic school placement of SED students have been held during the last year? ________
    What are the administrative costs? ______________
    What are the legal costs? ______________
7. How many private psychological evaluations has education paid for to comply with Public Law 94–142? ______________
    What is the total educational cost? ______________
    What is the cost for psychotherapy of SED students? ______________
8. How many Protective Services clients are placed in group homes or residential treatment? ______________
    What is the total AFDC/FC cost? ______________
    What is the average length of stay? ______________
    Average cost per month? ______________
    Average cost per episode? ______________
9. What is the social service case management caseload in out-of-home treatment of SED clients? ______________
    How many staff are assigned? ______________
    What are the staff costs? ______________
10. What is the total education cost paid by education for Protective Services clients placed in AFDC–FC court-ordered residential treatment with a nonpublic school program? ______________
    How many clients? ______________
    Average length of stay? ______________
    Average cost per episode? ______________
11. How many Juvenile Justice clients are placed directly in state hospitals as "not guilty by reason of insanity" or "incompetent to contribute to their own defense"? ______________
    What is the total cost? ______________
    Average length of stay? ______________
    Average cost per episode? ______________

12. What is the Juvenile Justice (Probation) case management caseload of mentally disordered offenders in out-of-home treatment? ____________
    How many staff are assigned? ____________
    What are the staff costs? ____________
13. How many Juvenile Justice clients are identified as mentally disordered and placed by the court in residential treatment? ____________
    What is the total AFDC–FC cost? ____________
    What is the average length of stay? ____________
    What is the average cost per month? ____________
    What is the average cost per episode? ____________
14. How many Youth Authority (state detention centers) clients are mentally disordered? ____________
    What is the Youth Authority cost of treatment for these clients? ______
    How many Youth Authority clients are transferred to the state hospital? ____________
    What are these costs? ____________
15. How many mentally disordered offenders are in Juvenile Hall and local detention facilities? ____________
    What services are provided? ____________
    What are the costs of this mental health treatment? ____________
    What is the recidivism rate (returned to court within 1 year) for untreated mentally disordered offenders in local detention facilities? ____________
    What court and probation costs are attributed to these offenders? ______

CHILDREN'S MENTAL HEALTH SERVICES DEMONSTRATION PROJECT LEGISLATION BILL 3920

Chapter 1474

An act to add and repeal Chapter 7 (commencing with Section 5575) of Part 1 of Division 3 of the Welfare and Institutions Code, relating to Juveniles, making an appropriate therefore.

(Approved by Government September 25, 1984. Filed with Secretary of State September 26, 1984.)

LEGISLATIVE COUNSEL'S DIGEST

AB 3920. Wright. Juveniles: mental health.

Existing law does not provide for a comprehensive system for the delivery of mental health services to children and youth, including families or foster families.

The bill would require the State Department of Mental Health to contract with the County of Ventura for the purpose of establishing a two-year demonstration project for developing and implementing a model children's comprehensive mental health service system, as specified. The bill would appropriate $200,000 to the department for purposes of this project. These provisions would be repealed on June 10, 1987.

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. Chapter 7 (commencing with Section 5575) is added to Part 1 of Division 5 of the Welfare and Institutions Code, to read:

CHAPTER 7. MENTAL HEALTH SERVICES FOR CHILDREN

5575. The Legislature finds that there is no comprehensive system for the delivery of mental health services to children and youth, including families or foster families. It further finds that services to children and youth are provided by various departments and agencies at both the state and county level, often without appropriate collaboration. The Legislature finds that mental health services to children in the County of Ventura are comparatively more comprehensive, involve more interagency collaboration, and provide a potential model program. Therefore, it is the intent of the Legislature to establish a two-year demonstration project in Ventura County to accomplish the following goals:

(a) Design and implement a comprehensive coordinated children's mental health service system as described in the 1983 State Department of Mental Health planning model.

(b) Build on existing service capabilities within the various agencies currently serving children's needs.

(c) Provide for a joint evaluation or interagency consultation by all publicly funded agencies for minors experiencing emotional disturbances.

(d) Identify statutory and regulatory changes that would facilitate interagency cooperation.

(e) Develop appropriate interagency protocols and agreements.

(f) Develop appropriate services for difficult to place children.

(g) Provide services in a manner that gives priority to permitting the minor to reside in his or her usual family setting.

(h) Where a joint evaluation indicates that out-of-home care and treatment is required, ensure that these services are provided in the least restrictive setting consistent with effective services, and in as close proximity as possible to the minor's usual residence.

(i) Conduct research into children's mental health services system in order that the system may be evaluated for effectiveness of treatment and cost benefit on an ongoing basis.

(j) Provide for other counties or regions a replicable model for a comprehensive, coordinated children's mental health service system.

5576. The State Department of Mental Health shall establish a two-year demonstration project in Ventura County for identifying and evaluating the county's interagency mechanism whereby local agencies serving emotionally disturbed minors with public funds are effectively collaborating with each other on behalf of these minors.

5577. (a) The State Department of Mental Health shall contract with the County of Ventura, according to the terms set forth in Section 5705.2 for the purpose of establishing a two-year demonstration project for developing and implementing a model children's comprehensive mental health service system. The program, as developed, shall meet the goals stated in Section 5575. The project shall include the various elements described in the proposed planning model for continuum of care for emotionally disturbed children and youth, published by the State Department of Mental Health in October 1983.

(b) The system developed pursuant to subdivision (a) shall include joint evaluation of the child and shall give priority to all of the following:

(1) Enabling the minor to remain at home whenever possible.

(2) Providing placement in the least restrictive and least costly setting consistent with the minor's needs.

(3) Enabling the minor to receive out-of-home services in as close proximity as possible to the minor's usual residence.

(c) The contract pursuant to subdivision (a) shall include research into the county's mental health services system for children and youth in order that the system may be evaluated for effectiveness of treatment and cost benefit on an ongoing basis, and identification of a model for a comprehensive coordinated children's mental health service system that can be replicated in other counties.

(d) The Director of Mental Health shall establish an advisory group comprised of, but not limited to, the following representatives from the appropriate state departments, children services coordinators designated by the Conference of Local Mental Health Directors, the Citizens Advisory Council and the local mental health advisory boards. The function of the advisory group shall be to advise and assist Ventura County in the development of replicable model programs and other duties as determined by the Director of Mental Health.

(e) The demonstration project shall begin on April 1, 1985, and shall continue through June 30, 1987. During this period the County of Ventura shall file progress reports each six months, beginning on December 1, 1985. The June 1, 1986 report shall also contain information on statutory and regulatory changes needed for interagency collaboration, and copies of interagency protocols and agreements that have been developed. The final report on the project shall be completed on or before June 30, 1987. This report shall be submitted to the State Department of Mental Health and to the Chairpersons of the Assembly Committee on Health, the Senate Committee on Health and Human Services, the Assembly Ways and Means Committee, and the Senate Finance Committee.

5578. The sum of two million eight hundred ninety-four thousand three hundred twenty-five dollars ($2,894,325) is the estimated cost of the demonstration project which shall be administered by the State Department of Mental Health in accordance with the following schedule:

(1) Two hundred thousand dollars ($200,000) as appropriated from the General Fund to the department for the 1984–85 fiscal year.

(2) The Legislature intends that one million five hundred forty-three thousand six hundred forty dollars ($1,543,640) shall be appropriated in the 1985–86 Budget Act for the next four quarters of the demonstration project.

(3) The Legislature intends that the remaining one million one hundred fifty thousand six hundred eighty-five dollars ($1,150,685) be appropriated from the 1986–87 Budget Act for the last three quarters of the demonstration project and wind down costs will be based on a review and evaluation of the demonstration project.

5579. This chapter shall remain in effect only until June 30, 1987 and as of that date is repealed, unless a later enacted statute, which is chaptered before June 30, 1987, deletes or extends that date.

References

Allen, M., Golubock, C., & Olson, L. (1983). A guide to the adoption assistance and child welfare act of 1980. In M. Hardin (Ed.), *Foster children in the courts* (pp. 575–609). Boston: Butterworth Legal Publishers.

Allen-Hagen, B. (1991, January). Public juvenile facilities, 1989: Children in custody. *Juvenile Justice Bulletin*, pp. 1–10.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev. ed.). Washington, DC: Author.

An Act Relating to Planning and Providing Services to Emotionally Disturbed Children. General Assembly, Commonwealth of Kentucky. House Bill 838. (1990).

Bailey, D. B. (1984). A triaxal model of the interdisciplinary team and group process. *Exceptional Children, 51*, 17–25.

Beck, J. A., Bartel, N. R., & Nelson, C. M. (1991). The growing need for multidisciplinary collaboration for students with disabilities. In L. M. Bullock & R. L. Simpson (Eds.), *Monograph on critical issues in special education: Implications for personnel preparation* (pp. 19–29). Denton, TX: University of North Texas.

Behar, L. (1985). Changing patterns of state responsibility: A case study of North Carolina. *Journal of Clinical Child Psychology, 14*, 188–195.

Behar, L. (1990). Financing mental health services for children and adolescents. *Bulletin of the Menninger Clinic, 54*(1), 127–139.

Bijou, S. W., & Baer, D. M. (1978). *Behavior analysis of child development*. Englewood Cliffs, NJ: Prentice-Hall.

Chamberlin, J., & Rogers, J. A. (1990). Planning a community-based mental health system. *American Psychologist, 45*, 1241–1244.

Cobb, J. A. (1972). Relationship of discrete classroom behaviors to fourth grade academic achievement. *Journal of Educational Psychology, 63*, 74–80.

Council for Children with Behavioral Disorders (1990). Position paper on the provision of service to children with conduct disorders. *Behavioral Disorders, 15*, 180–189.

C. R. v. Hornsby, U.S. District Court, Middle District of Alabama, No. 88-H-1170. (1991).

Dadds, M. R. (1987, September). Families and the origins of child behavior problems. *Family Process, 26*, 341–357.

Department of Health and Human Services, Public Health Service (1991). *Program announcement: Child and adolescent mental health service system research and demonstration grants*. Washington, DC: Department of Health and Human Services, National Institute of Mental Health.

Department of Public Policy, National Mental Health Association (1991). *Legislative alert: Children's mental health* (Alert No. 102–3). Alexandria, VA: Author.

Dumont, M. P. (1987). A diagnostic parable. *Readings: A Journal of Reviews and Commentary in Mental Health*, 2(4), 9–12.

Edgar, E. (1990). Quality of life for persons with disabilities: A time to change how we view the world. In R. B. Rutherford Jr. & S. A. DiGangi (Eds.), *Monograph in behavioral disorders: Severe behavior disorders of children and youth* (Vol. 13, pp. 1–10). Tempe, AZ: Arizona State University, Teacher Educators for Children with Behavioral Disorders, and Council for Children with Behavioral Disorders.

Edgar, E. B., Webb, S. L., & Maddox, M. (1987). Issues in transition: Transfer of youth from correctional facilities to public schools. In C. M. Nelson, R. B. Rutherford Jr. & B. I. Wolford (Eds.), *Special Education in the criminal justice system* (pp. 251–272). Columbus, OH: Merrill.

Elder, J. O., & Magrab, P. (Eds.). (1980). *Coordinating services to handicapped children: A handbook for interagency collaboration*. Baltimore: Paul H. Brookes.

Executive Committee of the Council for Children with Behavioral Disorders (1987). Position paper on definition and identification of students with behavioral disorders. *Behavioral Disorders, 13,* 9–19.

Forness, S. (1988). Planning for the needs of children with serious emotional disturbance: The National Special Education and Mental Health and Special Education and Mental Health Coalition. *Behavioral Disorders, 13,* 127–133.

Forness, S. (1989, April). *Testimony of national mental health and special education coalition on reauthorization of EHA*. Washington, DC: U.S. Senate Subcommittee on the Handicapped.

Freiberg, P. (1991, February). Study: Disorders found in 20 percent of children, The *APA Monitor*, p. 36.

Friedman, R. M. (1985). *Serving seriously emotionally disturbed children: An overview of major issues*. Unpublished manuscript, Florida Mental Health Institute, Tampa.

Friedman, R. M., & Street, S. (1985). Admission and discharge criteria for children's mental health services: A review of issues and options. *Journal of Clinical Child Psychology, 14,* 229–235.

Freidman, R. M., Duchnowski, A. J., & Henderson, E. L. (Eds.). (1989). *Advocacy on behalf of children with serious emotional problems*. Springfield, IL: Charles C Thomas.

Giangreco, M. F., York, J., & Rainforth, B. (1989). Providing related services to learners with severe handicaps in educational settings: Pursuing the least restrictive option. *Pediatric Physical Therapy, 1*(2), 55–63.

Gould, M. S., Wunsch-Hitzig, R., & Dohrenwend, B. (1981). Estimating the prevalence of childhood psychopathology: A critical review. *Journal of the American Academy of Child Psychiatry, 20,* 462–476.

Hart, V. (1977). The use of many disciplines with the severely and profoundly handicapped. In E. Sontag, J. Smith, & N. Certo (Eds.), *Educational programming for the severely and profoundly handicapped*. Reston, VA: The Council for Exceptional Children.

Howell, K. W., Kaplan, J. S., & O'Connell, C. Y. (1979). *Evaluating exceptional children: A task analysis approach*. Columbus, OH: Merrill Publishing Co.

Idol, L., Paolucci-Whitcomb, P., & Nevin, A. (1986). *Collaborative consultation*. Rockville, MD: Aspen Systems Corporation.

Illback, R. (1991, March). SED evaluation progress report. Unpublished manuscript, Kentucky IMPACT.

Institute of Medicine (1989). *Research on children and adolescents with mental, behavioral, and developmental disorders.* Washington, DC: National Academy Press.

Isaacs, M. (1984). *An analysis of state administrative structures for the provision of coordinated services to children and youth.* Washington, DC: Alpha Center.

Jackson, S. (1991). Alabama consent decree aims to transform child welfare system. *Youth Law News, 12*(3), 1–5.

Jacobs, J. H. (1990). Child mental health: Service system and policy issues. *Social Policy Report: Society for Research in Child Development. 4*(2), 1–19.

Johnson, H. C. (1989). Behavior disorders. In F. J. Turner (Ed.), *Child psychopathology: A social work perspective.* (pp. 73–140). New York: The Free Press.

Joint Commission on the Mental Health of Children (1969). *Crisis in child mental health.* New York: Harper & Row.

Josh L. v. Symington, CIV 91-261. (1991).

Kauffman, J. M. (1989). *Characteristics of behavior disorders of children and youth* (4th ed.). Columbus, OH: Merrill Publishing Co.

Kennedy, E. M. (1990). Community-based care for the mentally ill: Simple justice. *American Psychologist, 45,* 1238–1240.

Kentucky Cabinet for Human Resources (1989). *A plan to address the mental health needs of Kentucky's children and youth with severe emotional problems.* Frankfort, KY: Author.

Kentucky Cabinet for Human Resources (1990). *Kentucky's comprehensive mental health services plan on behalf of adults with severe mental illness and children and youth with severe emotional problems.* Frankfort, KY: Kentucky Cabinet for Human Resources, Department for Mental Health and Mental Retardation Services, Division of Mental Health.

Kerr, M. M., & Nelson, C. M. (1989). *Strategies for managing behavior problems in the classroom* (2nd ed.). Columbus, OH: Merrill Publishing Co.

Kerr, M. M., & Zigmond, N. (1984). *School survival skills: Grant report for year three.* Unpublished document, University of Pittsburgh.

Kerr, M. M., Zigmond, N., Schaeffer, A. L., & Brown, G. (1986). An observational follow-up study of successful and unsuccessful high school students. *High School Journal, 71,* 20–32.

Kirst, M. W. (1990, April). *Improving children's services: Overcoming barriers, creating new opportunities.* Paper presented at the annual meeting of the American Educational Research Association, Boston.

Knitzer, J. (1982). *Unclaimed children: The failure of public responsibility to children and adolescents in need of mental health services.* Washington, DC: Children's Defense Fund.

Knitzer, J. (1984). Mental health services to children and youth: A national view of public policies. *American Psychologist, 39,* 905–911.

Knitzer, J. (1989). Children's mental health: The advocacy challange "and miles to go before we sleep". In R. M. Friedman, A. J. Duchnowski, & E. L. Henderson (Eds.), *Advocacy on behalf of children with serious emotional problems* (pp. 15–27). Springfield, IL: Charles C Thomas.

Knitzer, J., Steinberg, Z., & Fleisch, B. (1990). *At the schoolhouse door: An examination of programs and policies for children with behavioral and emotional disorders.* New York: Bank Street College.

Knoff, H. M. (1990, December). Summarizing the important elements of early childhood primary prevention programs for emotional and behavioral problems. *Communique*, pp. 8–10.

Landerholm, E. (1990). The transdisciplinary team approach in infant intervention programs. *Teaching Exceptional Children, 22*, 66–70.

Lane, T. W., & Burchard, J. D. (1983). Failure to modify delinquent behavior: A constructive analysis. In E. B. Foa & P. M. G. Emmelkamp (Eds.), *Failures in behavior therapy* (pp. 355–377). New York: John Wiley & Sons.

Leone, P. E. (1990). Toward integrated perspectives on troubling behavior. In P. E. Leone (Ed.), *Understanding troubled and troubling youth* (pp. 15–22). Newbury Park, CT: Sage Publications

Lyon, S., & Lyon, G. (1980). Team functioning and staff development: A role release approach to providing educational services for severely handicapped students. *Journal of the Association of the Severely Handicapped, 5*, 250–263.

Magrab, P., & Elder, J. O. (Eds.) (1980). *Planning for services to handicapped persons: Community, education, health*. Baltimore: Paul H. Brookes.

McConaughy, S. M., & Achenbach, T. M. (1989). Empirically based assessment of serious emotional disturbance. *Journal of School Psychology, 27*, 91–117.

McConnell, S. R., Strain, P. S., Kerr, M. M., Stagg, V., Lenkner, D. A., & Lambert, D. L. (1984). An empirical definition of elementary school adjustment: Selection of target behaviors for a comprehensive treatment program. Behavior Modification, 3, 451–473.

Morsink, C. V., Thomas, C. C., & Correa, V. I. (1991). *Interactive teaming: Consultation and collaboration in special programs*. Columbus, OH: Merrill.

Multi-agency Network for Severely Emotionally Disturbed Children. (1987). *Building and managing the multi-agency case plan*. Tallahassee, Florida.

Multi-agency Network for Severely Emotionally Disturbed Children (1989). *Building and balancing the system of care through early intervention case management*. Tallahassee, FL: Florida Department of Health and Rehabilitation Services.

National Association of State Directors of Special Education (1990, October). *Education of the Handicapped Act amendments of 1990 (Public Law 101–476): Summary of major changes in parts a through h of the act*. Washington, DC: Author.

Nelson, C. M. (1989, February). *The role of therapy in educational programs for behaviorally disordered students*. Paper presented at the Midwest Leadership Symposium in Behavior Disorders, Kansas City, MO.

Nelson, C. M., & Pearson, C. A. (in press). Delinquency in the context of culture and community. In R. L. Peterson & S. Ishii-Jordan (Eds.), *Behavior disorders in the context of culture and community*. Boston: Brookline Press.

Nelson, C. M., Rutherford, R. B., Center, D. B., & Walker, H. M. (1991). Do public schools have an obligation to serve troubled children and youth? *Exceptional Children, 57*, 406–415.

Pallak, M. S. (1990). Community-based care for the mentally ill: Client outcome orientation in research, program planning, and service delivery. *American Psychologist, 45*, 12–37.

Patterson, G. R., Reid, J. B., Jones, R. R., & Conger, R. E. (1975). *A social learning approach to family intervention: Vol. 1. Families with aggressive children*. Eugene, OR: Castalia.

Peacock Hill Working Group (1991). Problems and promises in special education and related services for children and youth with emotional or behavioral disorders. *Behavioral Disorders, 16,* 299–313.

Phillips, V. (1990). *Kentucky IMPACT's one-hour model: Facilitation of child-specific team meetings.* Frankfort, KY: Kentucky Department of Education.

Phillips, V. (1991). *Successful interagency collaboration: A matter of coordination or attitude?* Unpublished manuscript, University of Kentucky, Lexington.

Phillips, V., & McCullough, L. (1990). Consultation-based programming: Instituting the collaborative ethic in schools. *Exceptional Children, 56,* 291–304.

President's Commission on Mental Health (1978). *Report of the sub-task panel on infants, children and adolescents.* Washington, DC: U.S. Government Printing Office.

Quay, H. C. (1986). Classification. In H. C. Quay & J. S. Werry (Eds.), *Psychopathological disorders of childhood* (3rd ed.) (pp. 1–334). New York: Wiley.

Quay, H. C. (1989, November). *Defining behavior disorder and determining eligibility for special education services: Interrelated but separate processes.* Paper presented at the Annual Rose Jenkins Conference, Sacramento, CA.

Regional Resource Center Task Force on Interagency Collaboration (1979). *Interagency collaboration on full services for handicapped children and youth.* Washington, DC: U.S. Department of Health, Education, and Welfare, Bureau of Education for the Handicapped.

Robert Wood Johnson Foundation (1988). *Mental health services program for youth.* Roseland, NJ: Presidential Insurance Company.

Romeo, T. D., Mauch, D., & Morrison, E. (1990). A catalyst for change: The art of strategic mental health planning in Rhode Island. *American Psychologist, 45,* 1253–1256.

SED Network Conference (1987, May). Conference presentations, *Multiagency collaboration through policy and practice,* Clearwater. Tallahassee, FL: Florida Department of Education.

Singh, N. N., Parmelee, B. S., Sood, B., & Katz, R. C. (in press). Collaboration of disciplines. In J. L. Matson (Ed.), *Handbook of hyperactivity in children.* New York: Pergamon Press.

Stroul, B. A., & Friedman, R. M. (1986). *A system of care for severely emotionally disturbed children and youth.* Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center.

Thomas, M. A., & Bunsen, T. D. (1990). *Special projects: An historical analysis.* Washington, DC: Office of Special Education Programs, U.S. Department of Education.

U. S. Department of Education, Office of Special Education and Rehabilitative Services. (1986). *Eighth annual report to Congress on the implementation of Public Law 94–142.* Washington, DC: Author.

U.S. Department of Education, Office of Special Education and Rehabilitative Services. (1990). *To assure the free appropriate public education of all handicapped children.* (Twelfth annual report to Congress on the implementation of the Education of the Handicapped Act). Washington, DC: Author.

Wagner, M. (1989). *The national longitudinal transition study.* Palo Alto, CA: Stanford Research Institute.

Wagner, M., & Shaver, D. (1989). *Educational programs and achievements of secondary special education students: Findings from the National Longitudinal Transition Study*. Palo Alto, CA: Science Research Associates.

Walker, H. M., & Bullis, M. (1991). Behavior disorders and the social context of regular class integration: A conceptual dilemma. In J. W. Lloyd, N. N. Signh, & A. C. Repp (Eds.), *The regular education initiative: Alternative perspectives on concepts, issues, and models* (pp. 75–94). Sycamore, IL: Sycamore Press.

Walker, H. M., & Fabré, T. R. (1987). Assessment of behavior disorders in the school setting. Issues, problems, and strategies revisited. In N. G. Haring (Ed.), *Measuring and managing behavior disorders* (pp. 198–243). Seattle: University of Washington Press.

Walker, H. M., & Rankin, R. (1983). Assessing the behavioral expectations and demands of less restrictive settings. *School Psychology Review, 12*, 274–284.

Walker, H. M., Severson, H., Stiller, B., Williams, G., Haring, N., Shinn, M., & Todis, B. (1988). Systematic screening of pupils in the elementary age range at risk for behavior disorders: Development and trial testing. *Remedial and Special Education, 9*(3), 8–14.

Webb, S. L., Maddox, M., & Edgar, E. (1985). *Juvenile corrections interagency transitions model*. Seattle, WA: Networking and Evaluation Team, Experimental Education Unit, Child Development and Mental Retardation Center, University of Washington.

Weithorn, L. A. (1988). Mental hospitalization of troublesome youth: An analysis of skyrocketing admission rates. *Stanford Law Review, 40*, 773–838.

Willie M. et al., v. James B. Hunt, Jr. et al., 564. Supp. 363 (W. D. North Carolina, 1983).

Wolery, M., Bailey, D. B., & Sugai, G. M. (1988). *Effective teaching: Principles and procedures of applied behavior analysis with exceptional students*. Boston: Allyn & Bacon.

Wolf, M. M. (1978). Social validity: The case for subjective measurement or how applied behavior analysis is finding its heart. *Journal of Applied Behavior Analysis, 11*, 203–214.

Wolf, M. M., Braukmann, C. J., & Ramp, K. A. (1987). Serious delinquent behavior as part of a significantly handicapping condition: Cures and supportive environments. *Journal of Applied Behavior Analysis, 20*, 347–359.

Wolfe, L. C. (1988). *Collaboration—some preliminary thoughts*. Unpublished manuscript. University of Kentucky, Lexington.

Yell, M. L. (1989). Honig v. Doe: The suspension and expulsion of handicapped students. *Exceptional Children, 56*, 60–69.